

1. THE GOALS OF COUNSELING

Any effective counseling depends upon the counselor's having certain clearly defined goals and objectives. The goals and objectives will differ with the institution in which a person works and the area of specialization he chooses. The following are goals of the pastor whether he is serving a local church or is on the staff of a pastoral counseling center. They are not attained all at once. All of them are not attempted in one interview. Not all of them may be needed by any one counselee; yet, in the main, these are the things a pastor hopes to do.

1. Reduce undue tension. Most counselees, perhaps all, have some tension, and some should have. One purpose of the pastor is to help counselees drain off their emotion and reduce their anxiety. This in itself is a real service and may be all that some people need.

2. Resolve harmful conflicts. Many people who come to the pastor are involved in conflict with spouse, children, parents, professors, employers, etc. Hostility, when it is uncontrolled, can destroy. Controlled anger can be positive in its results because understanding and love build.

3. Improve insight and self-understanding. Insight is more than a knowledge about oneself. It is an emotional understanding that enables one to understand his feelings and his tensions. Anything that promotes self-understanding is helpful to the counselee. There are occasions when insight is too threatening, or when it may lead to action that is inappropriate.

4. Increase self-acceptance. Most counselees have a poor self-image. They find it difficult to accept themselves as they are. Acceptance comes not by persuasion but by our acceptance of them and through their deeper understanding of their own needs and problems.

5. Release internal resources. Most people have within themselves resources of strength, which can be drawn upon. At times these need to be identified. At times a bit of encouragement, support, or reassurance will enable them to master their own ego strengths and cope with their own problems.

6. Provide information. Often the information that people have is limited, faulty, or confused by emotion. Some problems cannot be solved without clarifying confusion; some decisions cannot be reached without adequate information. At times the counselor is a "friendly teacher."

7. Foster continued growth. Not only must their immediate problems be solved and their immediate decisions be made, but persons must also grow in the process, they must attain new levels of behavior. That which fosters continued growth is the identification of rewards in the immediate situation.

8. Make realistic choices. Some persons come to the pastor facing decisions about marriage, education, or careers. People need to be helped to make intelligent choices and realistic plans toward their realization, if these are possible.

9. Improve interpersonal relationships. A basic purpose of all pastoral work is to help people understand and accept each other--in other words, to help persons love and be loved.

10. Attain self-fulfillment and self-actualization. Pastoral counseling is concerned not only with resolving conflicts, but with movement towards attaining one's potential, and the realization of meaning and purpose.

11. Deepen spiritual resources. People need to discover spiritual resources, to deepen their understanding of spiritual resources, and to live lives of faith. This is not easy; it varies with the person's background and with the counselor's own experience, but it is the ultimate goal of pastoral counseling.

While skills and techniques are important, one of the most influential factors in pastoral counseling is the attitude of the counselor. The following list is something of a checklist. No one has ever attained all the things on the list to perfection. On some days and with some persons, our attitudes are more positive than others. Actually, attitudes all overlap and combine to make up a person's total approach. The following list of attitudes may be used as a guide for self-evaluation and growth, and should be developed and maintained.

1. Concentration. Achievement in any important field demands intense concentration: athletics, scholarship, research, the arts. It is equally true of counseling. The counselee should feel and know that the counselor is giving him his undivided attention.

2. Understanding. No person fully understands another. We only understand in part, but it helps the counselee if he feels the counselor is making every effort to understand him.

3. Respect. We are using this in a religious sense. The pastoral counselor sees every man as a child of God and therefore worthy of his efforts and attention.

4. Acceptance. Every person must be accepted as a person of unconditional worth. This does not mean that evil is ignored or misbehavior condoned. It means that the pastoral counselor must accept the counselee in spite of his behavior, his opinions, or his beliefs. This acceptance must be sincere. If the person really feels accepted, he will be helped.

5. Objectivity. This does not mean aloofness, professionalism, or indifference. A pastoral counselor must be involved, related to the counselee in depth, but always objectively. This is one of his greatest services. A person cannot be objective about himself.

6. Patience. Counseling takes time. Progress is often slow. One outstanding pastor said, "There's something about the slow, hard task of changing life that few have the patience to endure." Actually, remarkable results do take place with a relatively small expenditure of time. It is easy not to recognize this and to become impatient. The pastor must be patient.

7. Confidence. The pastoral counselor must work with confidence. He must be confident of his methods. He must have confidence in the counseling process. This requires thorough, careful, and continued preparation and study.

8. Optimism. Optimism can be neither superficial nor sentimental. It must be genuine and sincere. The Christian faith affirms that prodigals can become sons again. Secular therapists begin a situation believing that growth, change, and understanding can take place. The pastoral counselor can do no less. The counselees have little confidence and are often pessimistic and discouraged. The pastoral counselor must maintain hope.

9. Love. Again we would stress that this cannot be superficial and sentimental; it must be objective and realistic. The pastoral counselor must care; he must care enough to become involved; he must care enough to be himself in the relationship with genuine concern and compassion.

10. Dedication. Frederick McKinney, in his book Counseling for Personal Adjustment,* says that a counselor's office should be a "sanctuary." A sanctuary by definition is a "holy" place. A worship room is called a sanctuary because sacred things take place there. Equally sacred things take place in a counseling room. People are making confession, facing decisions, looking at themselves, developing their potentiality, growing in understanding. Such matters can only be dealt with in a spirit of Christian commitment.

11. Faith. The pastoral counselor believes that God is more concerned about the counselee than the pastor is; therefore, he doesn't have to play God. He feels that God is present in the counseling situation though the word God may never be mentioned. It is because of his faith that the pastor can be patient and accepting and optimistic. In serving men he is in truth serving God, and therefore proceeds by faith.

PEOPLE UNDER STRESS

People who are under stress respond differently than people under average or normal conditions. Almost everyone who goes to a pastor or a counseling center for help is under some degree of stress or he would not go. Certain factors about people under stress should be kept in mind.

1. Stress is an individual thing. What creates stress for one person may not for another. Stress must be seen from the counselee's perspective. A situation that might not appear as one of stress for the pastor in his own circumstances may create considerable stress for the person in his circumstances.

2. Severe stress brings out the best and the worst in persons. Some may respond to stress with courage and renewed effort, while others may respond to the same situation by fear or withdrawal.

3. People who are under stress or in pain (one form of stress) become ego-centric. The central fact of the problem or the pain focuses the person's attention on himself. An extrovert may become an introvert. He may not be interested in others because of his concern about himself at the moment. Such a self-focus is usually transitory and disappears when the stress is relieved.

4. People under stress endow authority figures or those in the helping professions with magical or superhuman powers. They expect them to produce sudden dramatic changes in or solutions to their problems, or they may endow them with the power to destroy.

5. People under stress listen with strange intensity to words and ideas, especially from authority figures. Statements a counselor may make almost casually may be seized upon and remembered and distorted as providing great hope or great discouragement.

6. People under stress often revert to behavior responses of childhood. They may become dependent, cry, pout, become noncommunicative, etc.

7. People under stress have a great sense of urgency, almost of desperation. Their urgency may not be in accord with the facts; they may have more time to work on the problem than they realize.

8. People under stress tend to be confused in their thinking; they over- or underreact; they have difficulty seeing reality.

9. People under stress have difficulty in concentrating. A student may find it difficult to study; an adult may not be able to keep his mind on his job.

10. People under stress have difficulty in interpersonal relationships. They feel others do not understand them; they may be intolerant of others; they may attempt to hide their stress and to act natural, which only increases the tension.

11. People under stress have difficulty in their religious beliefs and experiences. They attend worship services but find little value in them. They find it difficult to pray, etc., or they may turn to religion with great hope.

12. Stress can thus be viewed in two perspectives, as promoting growth and therefore desirable (where solutions to the stress are probable and possible), or resulting only in frustration and therefore destructive.

COUNSELING TECHNIQUES

A variety of counseling techniques are available to the pastoral counselor. Historically, pastoral counseling has consisted of exhortation, reassurance, at times, moralizing; and, usually, the giving of advice. With the development of the psychological sciences and the popularity of psychotherapy, pastors have had to re-evaluate and refine their methods. Every pastor must work in his own way. He should be familiar with the various techniques available, know when they are most appropriate, and recognize the values and limitations of each. The particular technique that is used in any interview depends on the needs of the person being counseled and also on the experience and personality of the counselor. One may use different methods with different persons, or different methods with the same person, depending upon what is indicated at the moment. The following suggestions may be helpful.

1. Listening. Listening is almost always useful in the early stages of an interview. In many cases someone to listen to him is all the counselee needs. (See Sect. 5 on "Listening.")

2. Reflection of Feelings. This method, made popular by Carl Rogers, is useful to the pastoral counselor. It fosters acceptance, gives a feeling of being understood, and leads to insight in the counselee. It should be noted that what is being discussed is a "reflection of feelings," not a "parroting" back of intellectual content. With some persons this may arouse resistance and frustration.

3. Questioning. Questioning is sometimes referred to as probing. What is meant is not an obtrusive, overly aggressive use of questions. At times the pastor needs more information, or the counselee needs to weigh alternatives, etc.; these goals can be pursued by asking questions. Open-ended questions are better than Yes or No questions unless one simply wants factual information. Structured questions are sometimes helpful in enabling the counselee to secure a better evaluation of reality.

4. Interpretation. At times the pastor may want to interpret to a person what he feels the person's situation is, what the causes of his behavior are, etc. Interpretation should be attempted with great caution and usually should be tentative. If the counselor is wrong but the counselee accepts his interpretation as fact, the exercise may be more confusing than helpful.

5. Reassurance and Support. These are great resources for the pastor. Because of his symbolic role, he can use them with power. Some persons, especially those with situational problems, may find these to be all they need. However, reassurance and support also should be used with caution. Too much reassurance received too quickly or too easily deprives the person of the right of grappling with his problem, and may even imply that the pastor does not understand him.

6. Confrontation and Advice. Occasionally a person must be confronted with the reality of a situation he is evading, or with the way his behavior affects others, or with the fact that he is wrong. This is never easy (if the counselor enjoys it, he should check his own motives). On the other hand, confrontation is not necessarily negative. It can be very therapeutic. While it is considered better for a person to come to his own insights, there are also occasions when the pastor must make specific statements.

7. Religious Resources. The pastor has available the resources of the Church, the sacraments, prayer, and Scripture, the healing power of religious concepts such as forgiveness, grace, redemption, and salvation (see Sect. 39, "Religious Resources").

SUPPORTIVE COUNSELING

Sustaining is what is commonly called "supportive counseling," or what some have called in more informal terms the ministry of "standing by." This is a tremendously powerful matter, a service that the minister is uniquely qualified to fulfill, and one that is all some counselees need.

The literature on psychotherapy distinguishes between depth and insight therapy and supportive therapy. Insight therapy usually though not always attempts to explore the past and the present to discover causes for behavior, and to help a person gain insight or understanding of his needs and problems. When properly done it can be very helpful.

There are other occasions when insight therapy is not indicated, when it might even be unkind or dangerous. When the disturbance in a person is very great, or his ego-strength weak, an attempt to gain insight or extend responsibility may not be the best procedure. On such occasions support, reassurance, and strength are the primary need.

What Are Supportive Methods?

Supportive counseling involves many techniques. Just "being there is one. In the parish, pastoral calling often falls in this category. At the church or in a counseling center the technique consists of having the pastor available and having a place where a person can come and discuss his concerns.

Showing genuine concern is another type of supportive counseling. In an impersonal, urbanized society many people have no one who is genuinely concerned about them. The pastoral counselor who can demonstrate sincere concern provides real support to such people.

Listening and reflecting feelings which show one's interest and concern can lend real support.

Asking questions, even taking a personal history, lends some support. This too shows concern.

Validating or confirming to a person the actual or emotional reality of his experience can provide support.

Reassurance, providing it is not superficial and overdone, provides real strength.

Providing information when it is needed, or making suggestions as to possible solutions or procedures can be very supporting.

On occasion, furnishing practical help, especially with the elderly, the young, the foreign-born, or the confused, can have a supportive value beyond the actual help that is offered. The help that is offered may take many forms: shopping for a shut-in, helping someone find a job, etc.

Religious resources, such as prayer, scripture, devotional reading, can be of great help to those for whom they have meaning.

While a pastor's attitudes can hardly be called a technique, his attitudes are perhaps the most influential of all factors. Moods are contagious. If the pastor is nervous, tense, anxious, it will be communicated to the counselee. Quiet, calm assurance can be of great support.

The telephone can be used very effectively in a supportive way. There are persons who cannot get away to come to the office, and many who do not need to be seen every day, or even two or three times a week, but the suggestion that they call and have a brief conversation can be very supportive.

Supportive counseling is often quite informal. On occasion, what the pastor actually does may seem so minimal some would discount it, but it should never be minimized.

Supportive counseling focuses on the present situation, except where a clarification of the past may serve to relieve anxiety or guilt. It does not attempt to probe the past. Its goal is not to produce radical personality change, but to help the person draw on his own inner resources and use them more effectively in meeting his present situation.

Supportive counseling depends greatly on an understanding relationship. (See Section 3, "The Pastoral Counseling Relationship.") A good relationship is a powerful force. It does give one the feeling he is understood; it helps a person gain perspective; it provides reassurance and increases strength.

Like all things supportive counseling can be misused. It can foster dependency feelings, particularly if the counselor uses it to exploit the patient, or to increase his own ego-needs. Too much reassurance can be superficial and can weaken rather than strengthen the counseling relationship.

Elements of support are probably present in every counseling relationship, and in most cases they are valuable. It does not mean they are the only method. When other procedures, such as insight counseling, or referral, are called for, they should be utilized.

What strengths are present within this family or this individual?
How can the persons involved be helped to realize the strengths they have?
What latent strengths are present that can be recognized or realized?
What new strengths could be developed?
How can these persons develop and utilize potential strengths?

When Is Supportive Counseling Indicated?

1. In situational problems, such as crisis situations or periods of temporary stress. In some cases this is only a temporary procedure and may lead to more intensive counseling at a later time.

2. In long-term problems where the person does not need intensive therapy but does need occasional support.

3. With persons where insight would be too threatening. If the actual reality would be so extremely traumatic it would create more tension than it would resolve, then support is indicated.

4. With situations that cannot be changed, such as old age, long convalescence, etc.

5. With a person whose husband (or wife, as the case may be), is in intensive therapy, perhaps hospitalized. The husband or wife may not need depth therapy, but he or she does need support.

INSIGHT COUNSELING

Most of the people who go to a pastor or a counseling center go because they are confused, discouraged, or anxious, or because they feel guilty, inadequate, or angry. Many of these feelings can be relieved. More mature, constructive Christian feelings and actions can be made possible if people can be helped to understand why they feel as they do, what caused their difficulties, and what are the reasons for their feelings and conduct. This is traditionally known as "insight."

"Insight" has many definitions. According to the Encyclopedia of Mental Health the ordinary usage of the term insight refers to "the capacity or act of understanding a situation, other people, or oneself, and the ability to apprehend meaning and relationships of data that are presented."*

1. Generally speaking, the better the insight, the better the prognosis.

2. There are a variety of methods of helping a person to gain insight. The most common are:

a. Listening, which draws off emotion and enables a person to organize and clarify his feelings.

b. Interpretation, which gives a person possible explanations for his behavior.

c. Reflection of feelings, which enables a person to evaluate his own feelings free from threatening or inhibiting situations.

d. Confronting the person with inconsistencies and contradictions.

(See Section 14 for further definition of some of these techniques.)

3. Some insight may be superficial and may help a person feel better momentarily, but the old problem will return. Some may be deep and profound and lead to significant change. Insight is usually relative and may be difficult to attain. The counselor, therefore, works patiently and persistently.

4. The counselor often has insight into a person's problem ahead of the counselee. It may not be advisable to discuss insight too soon. This can be threatening. Timing is important.

5. Insight should not be hurried. People come to insight at their own pace. To force it too fast may create resistance.

6. Generally, it is undesirable to attempt to force insight on another or to try to give insight to another, although under some circumstances it is necessary and useful. The counselor's task is to help the person attain his own insight.

7. Insight may not guarantee improvement. Some people understand their behavior but do not have sufficient motivation to change.

8. Insight is not always indicated as the goal to be sought. There are situations where insight might be too threatening or too painful to be pursued. There are other situations where it is not necessary. Support and reassurance may be all that is required.

9. Some persons can attain insight better than others. Small children are not expected to attain self-understanding as is described here. The elderly often have difficulty attaining insight although this is not always true. Generally speaking, the higher the level of intelligence, the better the possibilities of insight, while the retarded--those in the lower level of intelligence--have difficulty attaining insight. The lower the socioeconomic level of the counselee, the less effective is insight counseling. The reality pressures are so great they tend to respond more to action-oriented methods, although there are always exceptions to all of these.

10. The ultimate goal is not only to help a person attain understanding, but also to put his understanding into action; to replace inappropriate, negative, or positive feelings and behavior with more mature, creative, self-actualizing behavior.

THE SEARCH FOR MEANING

Viktor Frankl says that "the search for meaning in life is the taproot of human striving." This is the position of those who belong to the schools known as "existential psychotherapy"

1. Every man is unique and must find meaning that is real for him in his own situation. Responsibility for this is shared by the counselor as well as the counselee.

2. Emphasis is placed primarily in the present. Little time is spent in probing the past. The basic emphasis is, "What meaning can be found now?"

3. The pastor, like the existential therapist, utilizes any or all methods that contribute to the goal. There are no methods that are unique to existential therapy. Any method that increases the sense of meaning is appropriate.

4. This "search for meaning" emphasis, or this approach can be used either with individuals or with groups. The goals are the same.

5. Some meaning can be found in any situation, even the most difficult or discouraging. This is a statement of faith, but it is all important.

6. Meaning is not found primarily by catharsis or persuasion, but often by confrontation and challenge.

7. The pastor's goal is to discover and release the meaning that already exists by virtue of the fact that the counselee is a child of God.

8. Meaning is ultimately found not through intellectual processes alone, but by action and commitment. It depends not only on understanding, but also on decision and dedication.

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The literature on psychotherapy distinguishes between depth and insight therapy and supportive therapy. Insight therapy usually though not always attempts to explore the past and the present to discover causes for behavior, and to help a person gain insight or understanding of his needs and problems. When properly done it can be very helpful.

There are other occasions when insight therapy is not indicated, when it might even be unkind or dangerous. When the disturbance in a person is very great, or his ego-strength weak, an attempt to gain insight or extend responsibility may not be the best procedure. On such occasions support, reassurance, and strength are the primary need.

What Are Supportive Methods?

Supportive counseling involves many techniques. Just "being there is one. In the parish, pastoral calling often falls in this category. At the church or in a counseling center the technique consists of having the pastor available and having a place where a person can come and discuss his concerns.

Showing genuine concern is another type of supportive counseling. In an impersonal, urbanized society many people have no one who is genuinely concerned about them. The pastoral counselor who can demonstrate sincere concern provides real support to such people.

Listening and reflecting feelings which show one's interest and concern can lend real support.

Asking questions, even taking a personal history, lends some support. This too shows concern.

Validating or confirming to a person the actual or emotional reality of his experience can provide support.

Reassurance, providing it is not superficial and overdone, provides real strength.

Providing information when it is needed, or making suggestions as to possible solutions or procedures can be very supporting.

On occasion, furnishing practical help, especially with the elderly, the young, the foreign-born, or the confused, can have a supportive value beyond the actual help that is offered. The help that is offered may take many forms: shopping for a shut-in, helping someone find a job, etc.

Religious resources, such as prayer, scripture, devotional reading, can be of great help to those for whom they have meaning.

While a pastor's attitudes can hardly be called a technique, his attitudes are perhaps the most influential of all factors. Moods are contagious. If the pastor is nervous, tense, anxious, it will be communicated to the counselee. Quiet, calm assurance can be of great support.

The telephone can be used very effectively in a supportive way. There are persons who cannot get away to come to the office, and many who do not need to be seen every day, or even two or three times a week, but the suggestion that they call and have a brief conversation can be very supportive.

Supportive counseling is often quite informal. On occasion, what the pastor actually does may seem so minimal some would discount it, but it should never be minimized.

Supportive counseling focuses on the present situation, except where a clarification of the past may serve to relieve anxiety or guilt. It does not attempt to probe the past. Its goal is not to produce radical personality change, but to help the person draw on his own inner resources and use them more effectively in meeting his present situation.

Supportive counseling depends greatly on an understanding relationship. (See Section 3, "The Pastoral Counseling Relationship.") A good relationship is a powerful force. It does give one the feeling he is understood; it helps a person gain perspective; it provides reassurance and increases strength.

Like all things supportive counseling can be misused. It can foster dependency feelings, particularly if the counselor uses it to exploit the patient, or to increase his own ego-needs. Too much reassurance can be superficial and can weaken rather than strengthen the counseling relationship.

Elements of support are probably present in every counseling relationship, and in most cases they are valuable. It does not mean they are the only method. When other procedures, such as insight counseling, or referral, are called for, they should be utilized.

What strengths are present within this family or this individual?
How can the persons involved be helped to realize the strengths they have?
What latent strengths are present that can be recognized or realized?
What new strengths could be developed?
How can these persons develop and utilize potential strengths?

When Is Supportive Counseling Indicated?

1. In situational problems, such as crisis situations or periods of temporary stress. In some cases this is only a temporary procedure and may lead to more intensive counseling at a later time.
2. In long-term problems where the person does not need intensive therapy but does need occasional support.
3. With persons where insight would be too threatening. If the actual reality would be so extremely traumatic it would create more tension than it would resolve, then support is indicated.
4. With situations that cannot be changed, such as old age, long convalescence, etc.
5. With a person whose husband (or wife, as the case may be), is in intensive therapy, perhaps hospitalized. The husband or wife may not need depth therapy, but he or she does need support.

INSIGHT COUNSELING

Most of the people who go to a pastor or a counseling center go because they are confused, discouraged, or anxious, or because they feel guilty, inadequate, or angry. Many of these feelings can be relieved. More mature, constructive Christian feelings and actions can be made possible if people can be helped to understand why they feel as they do, what caused their difficulties, and what are the reasons for their feelings and conduct. This is traditionally known as "insight."

"Insight" has many definitions. According to the Encyclopedia of Mental Health the ordinary usage of the term insight refers to "the capacity or act of understanding a situation, other people, or oneself, and the ability to apprehend meaning and relationships of data that are presented."*

1. Generally speaking, the better the insight, the better the prognosis.
2. There are a variety of methods of helping a person to gain insight. The most common are:
 - a. Listening, which draws off emotion and enables a person to organize and clarify his feelings.
 - b. Interpretation, which gives a person possible explanations for his behavior.
 - c. Reflection of feelings, which enables a person to evaluate his own feelings free from threatening or inhibiting situations.
 - d. Confronting the person with inconsistencies and contradictions.

(See Section 14 for further definition of some of these techniques.)

3. Some insight may be superficial and may help a person feel better momentarily, but the old problem will return. Some may be deep and profound and lead to significant change. Insight is usually relative and may be difficult to attain. The counselor, therefore, works patiently and persistently.

4. The counselor often has insight into a person's problem ahead of the counselee. It may not be advisable to discuss insight too soon. This can be threatening. Timing is important.

5. Insight should not be hurried. People come to insight at their own pace. To force it too fast may create resistance.

6. Generally, it is undesirable to attempt to force insight on another or to try to give insight to another, although under some circumstances it is necessary and useful. The counselor's task is to help the person attain his own insight.

7. Insight may not guarantee improvement. Some people understand their behavior but do not have sufficient motivation to change.

8. Insight is not always indicated as the goal to be sought. There are situations where insight might be too threatening or too painful to be pursued. There are other situations where it is not necessary. Support and reassurance may be all that is required.

9. Some persons can attain insight better than others. Small children are not expected to attain self-understanding as is described here. The elderly often have difficulty attaining insight although this is not always true. Generally speaking, the higher the level of intelligence, the better the possibilities of insight, while the retarded--those in the lower level of intelligence--have difficulty attaining insight. The lower the socioeconomic level of the counselee, the less effective is insight counseling. The reality pressures are so great they tend to respond more to action-oriented methods, although there are always exceptions to all of these.

10. The ultimate goal is not only to help a person attain understanding, but also to put his understanding into action; to replace inappropriate, negative, or positive feelings and behavior with more mature, creative, self-actualizing behavior.

THE SEARCH FOR MEANING

Viktor Frankl says that "the search for meaning in life is the taproot of human striving." This is the position of those who belong to the schools known as "existential psychotherapy"

1. Every man is unique and must find meaning that is real for him in his own situation. Responsibility for this is shared by the counselor as well as the counselee.

2. Emphasis is placed primarily in the present. Little time is spent in probing the past. The basic emphasis is, "What meaning can be found now?"

3. The pastor, like the existential therapist, utilizes any or all methods that contribute to the goal. There are no methods that are unique to existential therapy. Any method that increases the sense of meaning is appropriate.

4. This "search for meaning" emphasis, or this approach can be used either with individuals or with groups. The goals are the same.

5. Some meaning can be found in any situation, even the most difficult or discouraging. This is a statement of faith, but it is all important.

6. Meaning is not found primarily by catharsis or persuasion, but often by confrontation and challenge.

7. The pastor's goal is to discover and release the meaning that already exists by virtue of the fact that the counselee is a child of God.

8. Meaning is ultimately found not through intellectual processes alone, but by action and commitment. It depends not only on understanding, but also on decision and dedication.

1. THE GOALS OF COUNSELING

Any effective counseling depends upon the counselor's having certain clearly defined goals and objectives. The goals and objectives will differ with the institution in which a person works and the area of specialization he chooses. The following are goals of the pastor whether he is serving a local church or is on the staff of a pastoral counseling center. They are not attained all at once. All of them are not attempted in one interview. Not all of them may be needed by any one counselee; yet, in the main, these are the things a pastor hopes to do.

1. Reduce undue tension. Most counselees, perhaps all, have some tension, and some should have. One purpose of the pastor is to help counselees drain off their emotion and reduce their anxiety. This in itself is a real service and may be all that some people need.

2. Resolve harmful conflicts. Many people who come to the pastor are involved in conflict with spouse, children, parents, professors, employers, etc. Hostility, when it is uncontrolled, can destroy. Controlled anger can be positive in its results because understanding and love build.

3. Improve insight and self-understanding. Insight is more than a knowledge about oneself. It is an emotional understanding that enables one to understand his feelings and his tensions. Anything that promotes self-understanding is helpful to the counselee. There are occasions when insight is too threatening, or when it may lead to action that is inappropriate.

4. Increase self-acceptance. Most counselees have a poor self-image. They find it difficult to accept themselves as they are. Acceptance comes not by persuasion but by our acceptance of them and through their deeper understanding of their own needs and problems.

5. Release internal resources. Most people have within themselves resources of strength, which can be drawn upon. At times these need to be identified. At times a bit of encouragement, support, or reassurance will enable them to master their own ego strengths and cope with their own problems.

6. Provide information. Often the information that people have is limited, faulty, or confused by emotion. Some problems cannot be solved without clarifying confusion; some decisions cannot be reached without adequate information. At times the counselor is a "friendly teacher."

7. Foster continued growth. Not only must their immediate problems be solved and their immediate decisions be made, but persons must also grow in the process, they must attain new levels of behavior. That which fosters continued growth is the identification of rewards in the immediate situation.

8. Make realistic choices. Some persons come to the pastor facing decisions about marriage, education, or careers. People need to be helped to make intelligent choices and realistic plans toward their realization, if these are possible.

9. Improve interpersonal relationships. A basic purpose of all pastoral work is to help people understand and accept each other--in other words, to help persons love and be loved.

10. Attain self-fulfillment and self-actualization. Pastoral counseling is concerned not only with resolving conflicts, but with movement towards attaining one's potential, and the realization of meaning and purpose.

11. Deepen spiritual resources. People need to discover spiritual resources, to deepen their understanding of spiritual resources, and to live lives of faith. This is not easy; it varies with the person's background and with the counselor's own experience, but it is the ultimate goal of pastoral counseling.

While skills and techniques are important, one of the most influential factors in pastoral counseling is the attitude of the counselor. The following list is something of a checklist. No one has ever attained all the things on the list to perfection. On some days and with some persons, our attitudes are more positive than others. Actually, attitudes all overlap and combine to make up a person's total approach. The following list of attitudes may be used as a guide for self-evaluation and growth, and should be developed and maintained.

1. Concentration. Achievement in any important field demands intense concentration: athletics, scholarship, research, the arts. It is equally true of counseling. The counselee should feel and know that the counselor is giving him his undivided attention.

2. Understanding. No person fully understands another. We only understand in part, but it helps the counselee if he feels the counselor is making every effort to understand him.

3. Respect. We are using this in a religious sense. The pastoral counselor sees every man as a child of God and therefore worthy of his efforts and attention.

4. Acceptance. Every person must be accepted as a person of unconditional worth. This does not mean that evil is ignored or misbehavior condoned. It means that the pastoral counselor must accept the counselee in spite of his behavior, his opinions, or his beliefs. This acceptance must be sincere. If the person really feels accepted, he will be helped.

5. Objectivity. This does not mean aloofness, professionalism, or indifference. A pastoral counselor must be involved, related to the counselee in depth, but always objectively. This is one of his greatest services. A person cannot be objective about himself.

6. Patience. Counseling takes time. Progress is often slow. One outstanding pastor said, "There's something about the slow, hard task of changing life that few have the patience to endure." Actually, remarkable results do take place with a relatively small expenditure of time. It is easy not to recognize this and to become impatient. The pastor must be patient.

7. Confidence. The pastoral counselor must work with confidence. He must be confident of his methods. He must have confidence in the counseling process. This requires thorough, careful, and continued preparation and study.

8. Optimism. Optimism can be neither superficial nor sentimental. It must be genuine and sincere. The Christian faith affirms that prodigals can become sons again. Secular therapists begin a situation believing that growth, change, and understanding can take place. The pastoral counselor can do no less. The counselees have little confidence and are often pessimistic and discouraged. The pastoral counselor must maintain hope.

9. Love. Again we would stress that this cannot be superficial and sentimental; it must be objective and realistic. The pastoral counselor must care; he must care enough to become involved; he must care enough to be himself in the relationship with genuine concern and compassion.

10. Dedication. Frederick McKinney, in his book Counseling for Personal Adjustment,* says that a counselor's office should be a "sanctuary." A sanctuary by definition is a "holy" place. A worship room is called a sanctuary because sacred things take place there. Equally sacred things take place in a counseling room. People are making confession, facing decisions, looking at themselves, developing their potentiality, growing in understanding. Such matters can only be dealt with in a spirit of Christian commitment.

11. Faith. The pastoral counselor believes that God is more concerned about the counselee than the pastor is; therefore, he doesn't have to play God. He feels that God is present in the counseling situation though the word God may never be mentioned. It is because of his faith that the pastor can be patient and accepting and optimistic. In serving men he is in truth serving God, and therefore proceeds by faith.

PEOPLE UNDER STRESS

People who are under stress respond differently than people under average or normal conditions. Almost everyone who goes to a pastor or a counseling center for help is under some degree of stress or he would not go. Certain factors about people under stress should be kept in mind.

1. Stress is an individual thing. What creates stress for one person may not for another. Stress must be seen from the counselee's perspective. A situation that might not appear as one of stress for the pastor in his own circumstances may create considerable stress for the person in his circumstances.

2. Severe stress brings out the best and the worst in persons. Some may respond to stress with courage and renewed effort, while others may respond to the same situation by fear or withdrawal.

3. People who are under stress or in pain (one form of stress) become ego-centric. The central fact of the problem or the pain focuses the person's attention on himself. An extrovert may become an introvert. He may not be interested in others because of his concern about himself at the moment. Such a self-focus is usually transitory and disappears when the stress is relieved.

4. People under stress endow authority figures or those in the helping professions with magical or superhuman powers. They expect them to produce sudden dramatic changes in or solutions to their problems, or they may endow them with the power to destroy.

5. People under stress listen with strange intensity to words and ideas, especially from authority figures. Statements a counselor may make almost casually may be seized upon and remembered and distorted as providing great hope or great discouragement.

6. People under stress often revert to behavior responses of childhood. They may become dependent, cry, pout, become noncommunicative, etc.

7. People under stress have a great sense of urgency, almost of desperation. Their urgency may not be in accord with the facts; they may have more time to work on the problem than they realize.

8. People under stress tend to be confused in their thinking; they over- or underreact; they have difficulty seeing reality.

9. People under stress have difficulty in concentrating. A student may find it difficult to study; an adult may not be able to keep his mind on his job.

10. People under stress have difficulty in interpersonal relationships. They feel others do not understand them; they may be intolerant of others; they may attempt to hide their stress and to act natural, which only increases the tension.

11. People under stress have difficulty in their religious beliefs and experiences. They attend worship services but find little value in them. They find it difficult to pray, etc., or they may turn to religion with great hope.

12. Stress can thus be viewed in two perspectives, as promoting growth and therefore desirable (where solutions to the stress are probable and possible), or resulting only in frustration and therefore destructive.

COUNSELING TECHNIQUES

A variety of counseling techniques are available to the pastoral counselor. Historically, pastoral counseling has consisted of exhortation, reassurance, at times, moralizing; and, usually, the giving of advice. With the development of the psychological sciences and the popularity of psychotherapy, pastors have had to re-evaluate and refine their methods. Every pastor must work in his own way. He should be familiar with the various techniques available, know when they are most appropriate, and recognize the values and limitations of each. The particular technique that is used in any interview depends on the needs of the person being counseled and also on the experience and personality of the counselor. One may use different methods with different persons, or different methods with the same person, depending upon what is indicated at the moment. The following suggestions may be helpful.

1. Listening. Listening is almost always useful in the early stages of an interview. In many cases someone to listen to him is all the counselee needs. (See Sect. 5 on "Listening.")

2. Reflection of Feelings. This method, made popular by Carl Rogers, is useful to the pastoral counselor. It fosters acceptance, gives a feeling of being understood, and leads to insight in the counselee. It should be noted that what is being discussed is a "reflection of feelings," not a "parroting" back of intellectual content. With some persons this may arouse resistance and frustration.

3. Questioning. Questioning is sometimes referred to as probing. What is meant is not an obtrusive, overly aggressive use of questions. At times the pastor needs more information, or the counselee needs to weigh alternatives, etc.; these goals can be pursued by asking questions. Open-ended questions are better than Yes or No questions unless one simply wants factual information. Structured questions are sometimes helpful in enabling the counselee to secure a better evaluation of reality.

4. Interpretation. At times the pastor may want to interpret to a person what he feels the person's situation is, what the causes of his behavior are, etc. Interpretation should be attempted with great caution and usually should be tentative. If the counselor is wrong but the counselee accepts his interpretation as fact, the exercise may be more confusing than helpful.

5. Reassurance and Support. These are great resources for the pastor. Because of his symbolic role, he can use them with power. Some persons, especially those with situational problems, may find these to be all they need. However, reassurance and support also should be used with caution. Too much reassurance received too quickly or too easily deprives the person of the right of grappling with his problem, and may even imply that the pastor does not understand him.

6. Confrontation and Advice. Occasionally a person must be confronted with the reality of a situation he is evading, or with the way his behavior affects others, or with the fact that he is wrong. This is never easy (if the counselor enjoys it, he should check his own motives). On the other hand, confrontation is not necessarily negative. It can be very therapeutic. While it is considered better for a person to come to his own insights, there are also occasions when the pastor must make specific statements.

7. Religious Resources. The pastor has available the resources of the Church, the sacraments, prayer, and Scripture, the healing power of religious concepts such as forgiveness, grace, redemption, and salvation (see Sect. 39, "Religious Resources").

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Synopsis of Suicide Prevention Workshop

I.

Suicidal Persons

1. Hard-Core - This is a person who is so determined to die, he kills himself quickly without leaving clues.
2. Ambivalent - This is a person who has mixed feelings about dying. This type of suicidal person often leaves clues.

Suicidal Erosion - This occurs when a person's ability to cope with stress, loss, frustration, and disappointment is being worn away. This process of erosion takes many years, therefore, suicide is a result of many causes which started many years prior. Negative elements in a family structure attributes to suicide. Ex: previous suicide in family, alcoholism, deterioration of family structure - loss of job, physical or verbal abuse of parents or children, etc.

II. ASSESSMENT

1. Situational - which may be conducive to suicidal feelings. Ex: loss of a loved one or loss of status.
2. Syndrome of depression and other symptoms.
 - a. Insomnia.
 - b. Inability to concentrate.
 - c. Loss of appetite of food or sex.
3. Verbal clues.
4. Behavioral clues - previous suicide attempt.

Risk Factors of Suicide

1. How long did previous attempt take place? The most current previous attempt, the higher the current risk.
2. How aware is the person of the lethality of suicide attempt?
3. What are the chances of someone intervening in suicide attempt? (neighbor, relative, etc.) If person aids in own rescue, present risk factor is lowered.
4. The degree of lethality. The greater the degree of lethality, the greater the risk factor.

ASK PERSON HOW THEY WOULD HARM THEMSELVES.

- S - How specific are details of suicide plan?
 - a. If person gives specific details, push panic button.
- A - Availability of proposed method.
- L - Level of lethality.
 - a. Method of suicide determines degree of risk factor.

* Take every suicide threat seriously! Do not ask person why he wants to kill himself. He will only respond with negative answers. If a person is willing to die, any instrument is a lethal weapon, including a pencil or even a person's own body.

** According to Dr. Marv Miller, when people are depressed, they do not have the energy to act out. It takes a certain level of energy to commit suicide. When people come out of depression or suicidal ideation quickly, therapist should react quickly, because this is the optimum time for suicide to occur.

People usually come out of deep depression slowly. The tendency to commit suicide occurs after the first 90 days after depression lifts. This is due to increased energy level to act out.

III. INTERVENTION

When you feel a person is suicidal

Confront person about feeling depressed and possibly causing harm to oneself. Conversation alone may save a person's life.

Role of Interventionist

1. Identify risk factors of person(s) having suicidal ideation.
2. Evaluate risk factors in person's life.
3. Make appropriate referrals.
4. Decrease hopelessness, increase hope in their lives.
5. Decrease person's helplessness.

Suicidal people will respond to voice of an authoritative figure. This is because suicidal people are in a highly suggestable and irrational state of mind.

Responding to a suicidal person

1. Build a trusting relationship.
 - a. "You did a very smart thing by contacting us. We have knowledge and experience in this area." Sound self-assuring.
2. Ask person specifically where he is.
3. Assess degree of risk using SAL approach.
 - a. Try to remove lethal instrument.
 - b. Do not leave person alone.
4. Identify major problems.
5. Assess persons resources.
 - a. Determine significant other and location.
 1. Significant other is the most influential person in potential suicides life.
 - b. Ask about successful coping strategies.
 - c. Are there relatives/friends that are helpful.
 - d. Find out what is still meaningful for person.
6. Mobilize person's resources.
 - a. Surround person with wall of support.
 1. Clergy.
 2. Doctor-therapist.
 3. Family, friends, neighbors.
7. Make appointment for person to go to Mental Health Center.

The Mythology of Suicide

- 1) MYTH - People who talk about killing themselves rarely commit suicide.
FACT - Most people who commit suicide have given some verbal clue or warning of their intentions.
- 2) MYTH - The tendency toward suicide is inherited and passed from generation to generation.
FACT - Although suicidal behavior does tend to run in families, it does not appear to be transmitted genetically.
- 3) MYTH - The suicidal person wants to die and feels that there is no turning back.
FACT - Suicidal people are usually ambivalent about dying and frequently will seek help immediately after attempting to harm themselves.
- 4) MYTH - All suicidal people are deeply depressed.
FACT - Although depression is often closely associated with suicidal feelings, not all people who kill themselves are obviously depressed. In fact, some suicidal people appear to be happier than they've been in years because they have decided to "resolve" all of their problems by killing themselves. Also, people who are extremely depressed usually do not have the energy to kill themselves.
- 5) MYTH - There is no correlation between alcoholism and suicide.
FACT - Alcoholism and suicide often go hand in hand. Alcoholics are prone to suicidal behavior and even people who don't normally drink will often ingest alcohol shortly before killing themselves.
- 6) MYTH - Suicidal people are mentally ill.
FACT - Although many suicidal people are depressed and distraught, most of them could not be diagnosed as mentally ill; perhaps only about 25 percent of them are actually psychotic.
- 7) MYTH - Once someone attempts suicide, that person will always entertain thoughts of suicide.
FACT - Most people who are suicidal are so for only a very brief period once in their lives. If the attempter receives the proper support and assistance, he will probably never be suicidal again. Only about 10 percent of the attempters later kill themselves.
- 8) MYTH - If you ask someone about his suicidal intentions, you'll only be encouraging him to kill himself.
FACT - Actually the opposite is true. Asking someone directly about his suicidal intentions will often lower his anxiety level and act as a deterrent to suicidal behavior by encouraging the ventilation of pent-up emotions through a frank discussion of his problems.
- 9) MYTH - Suicide is quite common among the lower class.
FACT - Suicide crosses all socioeconomic distinctions and no one class is more susceptible to it than another.
- 10) MYTH - Suicidal people rarely seek medical attention.
FACT - Research has consistently shown that about 75 percent of suicidal people will visit a physician within the month before they kill themselves.

Suicide continues to be one of the leading causes of death in the United States. Even more alarming is the increased incidence of suicide and suicide attempts among young people. This article looks at suicidal behavior and suggests practical counselor interventions to prevent suicide.

LEWIS B. MORGAN

The Counselor's Role in Suicide Prevention

At least 20,000 people commit suicide in the United States each year, making it the tenth leading cause of death (Klagsbrun, 1976). Many other suicides go unreported and do not show up in the statistics. Authorities (Klagsbrun, 1976) put the total number of suicide deaths closer to 100,000 per year, and the number of suicide attempts at 10 times that figure. This means that approximately 1 million Americans a year make the decision to take their lives and then take steps to implement that decision.

Suicides and attempts at suicide have been on the rise in recent years, especially among young people, women, and members of ethnic minority groups (Lee, 1979 "Nothing More to Live For", 1979). It is, however, a mistaken belief that only a certain "type" of individual attempts suicide. Suicide is and always has been sex, color, and age blind. It touches all segments of society; there is no such thing as a typical suicidal person (American Association of Suicidology, 1977).

Reasons for the dramatic increase in the suicide rate are largely unknown, although experts speculate that the societal changes that have taken place within the past decade or so—the breakdown of the family structure, changing value systems, a sense of rootlessness, a disillusionment with society's institutions—have something to do with the rise (Perlin, 1979).

The purpose of this article is not to trace the causes of suicide, but rather to help counselors recognize potential suicidal behavior and then to take appropriate, preventive action.

One question counselors and other helpers frequently ask themselves is, What right do I have to interfere with people who have decided to take their own lives? Philosophically this may be a valid question, but from a professional helper's view, there is little or no room for debate. Counselors are advocates of (for) life, even though they may personally believe individuals have the right to end their lives. It is crucial with suicidal clients that counselors not convey the message that they in any way endorse life-threatening behavior. To convey such a message

would constitute the most serious breach of professional ethics and negate the goals of counseling.

FOREWARNINGS OF SUICIDE

Schneidman (1965) groups signs or clues of suicide into four broad areas: verbal, behavioral, situational, and syndromatic.

1 *Verbal signs* include direct statements such as, I wish I were dead! I'm going to end it all! as well as indirect statements such as, No one cares whether I live or die! or Why is there such unhappiness in this life? The young female client, whose diary is presented in the accompanying text, has made many such direct and explicit statements.

2 *Behavioral clues* include, of course, any previous attempts at suicide by the client. Any attempt at suicide must be taken seriously by the counselor. Far too often we hear counselors say "It was only a way to get attention. That may be true, but such attention seeking reflects a pain-ridden human being's cry for help, and cannot be rationalized away. More subtle behavioral clues might include the making of a will, bequeathing one's body or organs to science, giving away prized possessions, or setting one's affairs in order.

3 *Situational clues* such as family strife, financial difficulties, or mutilative surgery can lead a person whose spirit is weakened or whose self-esteem is low to contemplate suicide. Some of the most common precipitating incidents in suicide are loss of a job, end of a marriage, and change of address—all of which are situational in nature.

4 *Syndromatic clues* pointing to potential suicidal behavior would include depression (probably the most prevalent syndrome of suicide); disorientation (those who respond to delusional "voices" to destroy themselves); defiance (individuals who insist on controlling their own destinies, including their own deaths); and dependence-dissatisfaction (people who perceive themselves as trapped and in a hopeless condition). Note how the diary echoes the young woman's feelings of aloneness and isolation.

The American Association of Suicidology (1977) lists five significant suicidal signals: (a) suicide threats or similar statements; (b) an attempt at suicide, (c) prolonged depression; (d) dramatic

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changes of behavior or personality; and (e) making final arrangements.

When any one of these signals is present, it is imperative that the counselor take the risk seriously and address the issue with the client in the most direct, forthright manner possible. Counselors too often mince words or try to couch their responses in a too-polite, too-genteel way when confronted with a suicidal client. Or they act in a judgmental manner and try to dissuade the client, or else attempt to cheer the person with false reassurances. None of these strategies works and, in fact, may only increase the danger of suicide because clients may then have additional evidence that no one—not even the professional—understands how painful their existence is.

COUNSELOR INTERVENTION STRATEGIES

What, then, can a counselor do that would be helpful in, literally, a life-or-death situation? First and foremost, the counselor must be willing to become deeply involved with the client. Many suicidal individuals tend to be dependent and somewhat childlike, so the counselor must initially assume the stance of a loving, caring, and firm parent figure. A totally adult, objective approach doesn't work as well because clients equate this with disinterest and aloofness. If the counselor responds with sincere empathy ("You must be experiencing a great deal of pain"), clients will recognize that their existential state is fully understood and accepted by the counselor.

Let the client know that you are available and can be reached at any hour of the day or night. Provide your work and home telephone numbers as well as the names, addresses, and telephone numbers of others who can help, such as crisis centers, hotlines, suicide prevention clinics, and professional colleagues. During the first counseling session, schedule the next appointment in *writing* and conclude with a statement such as, "That's an interesting point! Suppose we discuss it more fully on Tuesday. I am always reminded of one instance in which I did this with a suicidal client. She related to me in the following session that it was this slip of paper with my telephone number and her next appointment on it that stopped her from taking her life that weekend. She looked in her dresser drawer, saw the bottle of pills, saw the scrap of paper which I had given her, and fortunately selected the paper. Maintaining contact is vital, even when the counselor is not physically present."

Determine early whether the client has the means available to commit suicide. Are there pills? A gun? A knife? If so, and a person primed to commit suicide usually does have the means available, firmly ask the client to let you keep them for awhile.

Remain with the client when the danger of suicide seems imminent. It may be necessary to ask other professionals or family members to help. Although it is true a suicidal person cannot be watched 24 hours a day, every precaution must be taken to ensure that the suicidal person is not left alone during the immediate crisis period.

Contracting is a good way to increase involvement with a suicidal client. A counselor can let the client know that suicidal urges will occur from time to time, but that under no circumstances should the client carry through on the urge. A simple statement such as, "No suicide attempts while we're in therapy!" will suffice. The counselor should not be deluded, however, into a false sense of security with such client statements as "I'll try or I'll do my best." A contract is a contract—No suicide attempts while we're in therapy!

Suicidal clients often feel hopeless, as though there is no way out of their dilemma. It is important that the counselor helps instill hope, though not of a falsely reassuring kind. The counselor can help clients recognize the irrationality of their thinking (No one cares whether I live or die) by disputing these illogical beliefs, as in rational-emotive therapy (I care, or I've talked to your sister, and I know that she cares.) In fact, any strong, sincere I-messages from the counselor (I don't want you to take your life! or I like you and think you have a lot going for you!) go a long way in helping clients begin to think in more positive terms about themselves.

Counselors can also aid suicidal clients by helping them develop support systems. Families might be included in the therapy, clergy (if the person sub-

DIARY OF A SUICIDAL CLIENT

The following excerpts are taken from a diary of a 17-year-old female who experiences poor family relations and is beaten by her father. The diary was released by the client for inclusion in this article.

OCTOBER 7—I have thought of death lately. I feel death is near . . . I wish to write a will myself. I feel I will not see old age.

NOVEMBER 10—Death is very close to me, very close . . . I often dream in my sleep of death. It is so close to me. I can feel it. It is all around me and inside I am dying. A strange feeling death is.

DECEMBER 2—I am sick physically from the hurt. How I really need to talk, but I can't. I can't live with all this confusion so intense, so intense.

DECEMBER 9—I feel the bleakness of winter now, a dim remembrance of my past . . . so horrible. The same things are happening. I hate it. I need help. Help me please.

JANUARY 19—How empty I feel, how empty. To be totally alone, with others but alone. So what is left except for that quiet desolation.

FEBRUARY 5—[She meets with a counselor, and they talk. She feels befriended.]

FEBRUARY 10—Everyone's mad at me. I want to quit, leave school, family, everything. I'm really trying to be strong, but I can't do it. [That night she nearly runs the car into a pole, but swerves away at the last minute.]

APRIL 23—[She has been talking to the counselor for two months now. Strong emotions surface. She has come to realize some of her faulty logic and behavior and really incriminates herself.] To be part and accepted, what's that? I am dead inside, dead outside. Who cares? I do. I am struggling within myself. I don't see any worth in me at all. I want to kill myself. At least then people would realize I'm a person. No wonder I scare people away; I even scare myself with my sickness. . . . To death, to death. Life is dead in me. [At this point, she actually holds the pills in her hands, stares at them, then becomes angry with herself, thinks of her counselor, and drives over to see him. This marks the beginning of a new life for her.]

scribes to a religion), friends, peer counselors, groups for the suicide prone, et cetera.

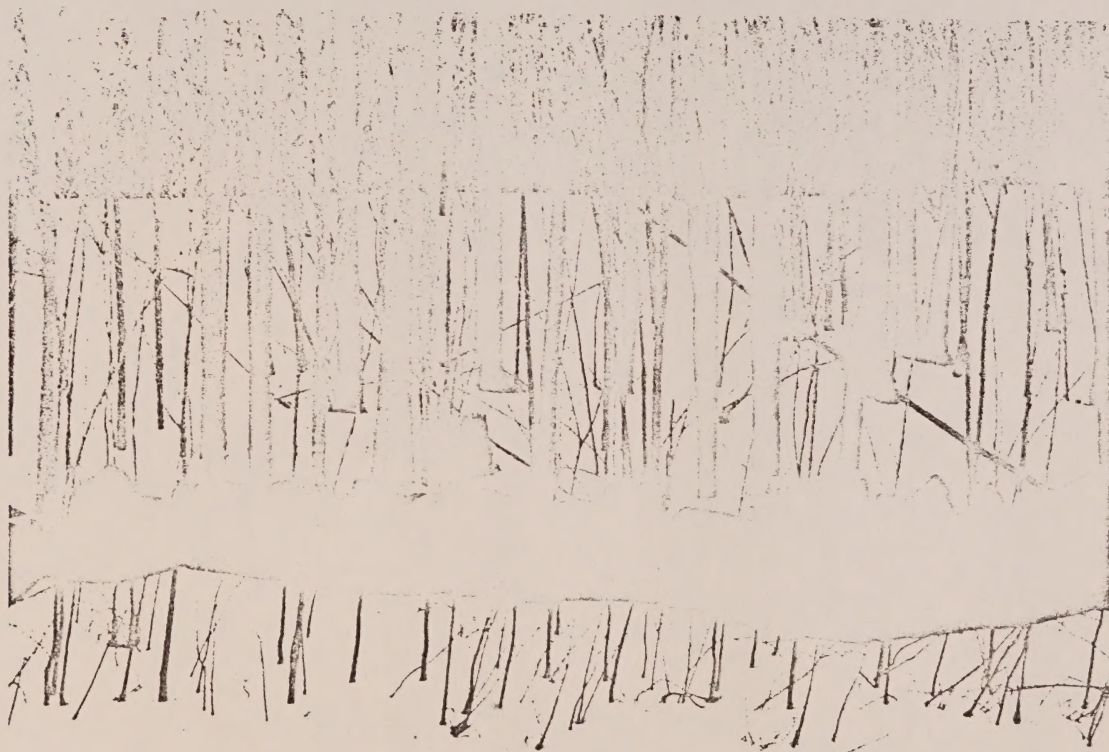
Because suicide is a reaction to stress in the client's life, any alleviation of stress is helpful. Stress can be alleviated through teaching the client relaxation techniques, or meditation, or encouraging some form of physical exercises like walking, jogging, or swimming. Early studies on the effect of running therapy with depressed clients have been highly positive.

One last point must be made: when the immediate crisis passes, it is critical that the involvement with clients be maintained. Most suicide attempts occur in the few months after apparent improvement, probably because it is during this period when they are able to muster the strength to carry out the act they were too weak or depressed to do previously. So, at all costs, maintain the contact after the immediate crisis is over.

Suicides can be prevented by counselors who are alert to and respond directly to the person harboring suicidal thoughts. It takes a strong, secure counselor to help such a person, but there is probably no deeper gratification for a counselor than to have been involved in this life-saving process.

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THE MASTURBATOR

After a few days of working at a Suicide and Crisis Service, answering calls from people in various types of difficulties and crises, the telephone therapist learns to respond to most problems with a type of "concerned objectivity". Yet some problems seem to tap a system of responses which generally is not therapeutic and leaves the therapist with a feeling of hurt, anger, or uselessness. One of the situations which probably does this more than any other is the call from a male who seems to use the services of the center for the sole purpose of masturbating to the voice of a female. For example, a few months ago, the following note was entered into our case file:

"A man masturbating while saying: "Talk to me. Don't leave me". I was not able to locate file but felt he had called before. As he became more excited he became more verbal with remarks like "Open your legs". I terminated call by suggesting he call back when he had finished to discuss why he needs a stranger rather than a friend at this time.

Over the past few months, this type of phone call has been received about three times a week.

The problems associated with this type of call can be divided into three categories: first, how to develop an appropriate treatment plan for this type of caller; second, how to deal with the feelings of the telephone therapist who receives the call; and third, the effect of this type of call on the service the agency is to perform in the community at large. It should be noted that these problems are not unique to calls from masturbators, but are associated with any type of difficult call that a telephone service receives. For example, females may call the center and act seductively to a male counselor, callers may arouse hostility and anger in counselors by the difficult problems they present, or callers who by their unwillingness to work with the telephone therapist evoke in them the feelings of inadequacy. Certainly the call from a person who is actively suicidal will raise the anxiety of the telephone therapist and may make it more difficult for him to react appropriately to the crisis situation.

Yet the masturbator does, perhaps, require special attention because his calls not only have a very disrupting effect on counselors by arousing very strong negative emotions in them which may result in their inadequate handling of the call but also because the aroused emotions generally have a negative effect on the handling of subsequent calls made by individuals with other types of problems.

From our analysis of the calls received at the center, there appears to be two types of masturbating callers. One type will discuss a problem which may or may not be fictional and, either the counselor will suspect that the caller is masturbating and confront him with this, or the patient himself will admit to masturbating. To this type of person, the counselors have reported feeling useless or "ineffectual", and, afterwards, furious at putting in hard work to no end". (1) The second type of caller merely breathes heavily and says words like: "talk to me", "don't leave me", "please let me finish", and so on. He may hang up frequently and then call

(1) These are the responses of female phone therapists. Our experience with this type of caller is that he will hang up whenever a male answers the phone.

back immediately. (2) To this type of person who does not allow the counselor to establish a relationship that can be seen by her as possibly therapeutic, the counselor reports feeling "used", "sexually exploited", "angry", "uptight", or "disgusted". These feelings are intensified if the counselor is alone at the center at night. Often the counselor feels that she can handle the situation intellectually, but not emotionally.

Without question, the therapist's feelings of anger, hostility, or disgust will interfere with the handling of this type of call. In most cases the counselor is responding to her own feelings rather than to the patient's problem. It appears that this may be a result of the counselor's attitudes toward "deviant" sexual behavior, her inability to know what a therapeutic response would be, or a combination of both. If the problem is the result of the counselor's attitude toward this type of behavior, it should be dealt with on an individual basis between her and her supervisor. The discussion would, of course, extend beyond the particular case of the masturbator to cover such issues as the counselor's attitudes towards sexual behavior in general and the feelings aroused when the counselor feels inadequate in the handling of a patient call. From our discussions with telephone counselors, it appears that their inability to respond therapeutically to the masturbator is a result of a lack of specific knowledge on the handling of this type of call combined with the intense emotional feelings of being "used" incorrectly by the caller. It is to these two issues that we would like to address ourselves.

Before discussing the possible handling of the masturbator, it might be well to discuss the philosophy of the telephone service. The unique feature of telephone therapy is its ability to respond immediately to individuals in difficulty on their own basis, with anonymity, and with the control remaining with the patient. In this type of therapy situation more than any other, the therapist is at a distinct disadvantage in that he does not have personal face-to-face knowledge of his patient. He has minimal clues with which to work and he must accept the fact that the patient has as much (possibly more) control of the situation as he does. It, therefore, is necessary for him to move into the problem situation on the patient's own bases, and only on the patient's bases. (3) If he does not do this, he may lose the patient, probably irretrievably, since in many cases he has no knowledge of the person's name, address, or phone number. It would, therefore, seem imperative that the axiom of meeting patients "where they are" would become the basic guideline for working with all types of difficult calls.

With this as a background we would like to list five possible approaches to handling the masturbator, in the hope that these suggestions would not only aid the counselor in a practical way when receiving such a call but also make alternative behaviors available to her so that she may feel more adequate in handling this type of caller.

1. The counselor can respond by saying nothing or with controlled silence.
- (2) On one occasion as many as 22 calls have been received from such an individual in the space of two hours.
- (3) We would like to emphasize that we are speaking here about the development of a relationship and not about the subsequent therapeutic movements.

2. The counselor can communicate her disgust to the caller and/or hang up.
3. The counselor can try to be accepting, but point out that the caller has a problem, that he could benefit from counselling, psychotherapy, or from seeing someone and talking about his problem, and then hang up.
4. The counselor could try to establish a minimal relationship with the masturbator, urge him to call her back after he has finished masturbating.
5. The counselor can stay with the caller, allow herself to be used if necessary, with the hope that the relationship can move from this level to one in which she can be more therapeutic to the person calling.

It appears to the authors that the first two approaches are at odds with the concept of a telephone service devoted to rendering therapeutic assistance to individuals in the community. Both of them either reject the patient overtly or communicate non-acceptance of the patient by the therapist. Without acceptance of the patient, regardless of his behavior or feelings, a therapeutic relationship is most difficult, if not impossible to establish. It could be argued however, that a strong negative response on the part of the counselor might negatively reinforce the behavior and cause it to extinguish. In a controlled therapy situation, this may take place. On the telephone, however, a more likely occurrence would be the calling of another person by the masturbator until he had obtained the verbal assistance of a female to complete his task. Mere rejection of the behavior by the therapist would appear to be of value only in allaying some of the therapist's feelings.

Response No. 3 is better but since many of the callers do not see masturbation as a problem, they may not see any reason for coming in for a face-to-face discussion. Indeed, it is most unlikely that this type of exchange will take place, for this person is unlikely to make himself known to the therapist. Also, this approach rejects, but to a lesser extent, the use of a telephone as a means of aiding the individual. However, if the counselor has personal concerns in handling such a call, this approach is probably the best for her to take.

Response No. 4 requires more acceptance of the patient by the counselor, but the chances of the person calling back after he has finished masturbating are probably slight. An extension of this approach would be for the counselor to suggest other stimuli for the masturbator to use to achieve sexual gratification in a more private manner, such as television, radio, or records. This may reduce the negative social aspects of the patient's behavior, but will also decrease the possibility of his receiving appropriate help.

Response No. 5 is clearly the best, in that the therapist is responding in a way that will maximize the chances for developing a relationship with the patient which may later be used for therapeutic purposes. It should be emphasized here, that acceptance of the person does not imply the reinforcing of the behavior or the condoning of it. It means tolerating the condition while attempting to develop a more honest, trusting relationship with the patient. The counselor of course must be careful not to be too seductive or encouraging. Conversely, she also must not be too confrontative to the

patient. To ask the person why he is masturbating may be too difficult a question for him to answer and impose too much distance between him, the counselor and his present behavior. The focus of the counselor should be on the effective relationship and the value of it for the patient. Perhaps the patient is lonely and depressed or is having difficulty in developing socially desirable relationships. Focusing on these areas may facilitate establishment of a more sustained and positive therapeutic relationship and may facilitate the patient's visit to a therapist if the relationship moves to a point where trust can be established between the patient and the counselor. Also focusing on the purpose or goal of the behavior seems to be more appropriate and less threatening than an attempt to discover the underlying genesis of the behavior. The patient can be asked what he feels his behavior is achieving for him, how he feels calling achieves this end for him, and how he sees his own behavior.

To use this last approach, the counselor must be aware of her own feelings in responding to this type of patient but keep them in the background. She must recognize that her approach to him must be one that meets him at the level of his needs, with the covert intent that if a relationship of trust can be established, the patient may look at his behavior in a more positive and therapeutic manner. Recognition must be given to the fact that this may never be achieved -- that the patient may simply use the therapist for his own end without any therapeutic movement on his part. Even though this may take place, and the therapeutic relationship be misused, we feel that the counselor on the telephone cannot set demands which might be appropriate when counseling a person on a face-to-face basis. Therefore, we feel that if a person can only relate on the telephone through masturbating, it is necessary to meet the person at this level, not to demand that he change his behavior, but hope that in the process of being used by him in this way in the present, a therapeutic movement can be made in the future.

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THE DEPENDENT CALLER

In any suicide prevention center, as well as in many other social agencies, much of the work concerns coping with dependent people. The reaction by professionals and para-professionals alike, has not always been adequate: excesses have ranged from a shocking fostering of the dependency, to a reaction of exasperation. Those in the helping profession know how difficult it is to cope with dependent people; what they want is more dependency on you, what you want is to help them become more independent. Both sides are determined to win, and feelings can run high in the process.

Why are some callers emotionally dependent, and how does one cope with them? For all of us, starting life means helplessness and complete dependency upon mother or upon the person who cares for us. This is a cozy, happy arrangement - mother loves it, you dearly love it. It provides physical and emotional security. But gradually, instinctual forces inspire you to investigate the world around you, to do things your own way, to become more and more independent. This is great, and it works well as long as dangers and threats, and their resulting anxiety, do not send you back to your mother's secure arms.

A proper education is one where parents gradually encourage you to become independent, able to cope with life's problems satisfactorily. Parents do that successfully if and when they are strong themselves and if they can offer the emotional and physical security as well as all the values needed to reach maturity. Unfortunately, as you may suspect, our parents are very much human beings with limitations and emotional handicaps. Often, also, their partnership can add to their individual problems, such as when an over-protective woman manages to marry a weak man, and forever after encourages him, in a sense, to remain weak, either as an alcoholic, for example, or as a rigid, easily upset individual.

So from early childhood and therefore from dependency and helplessness, there is quite a step toward adulthood, and none of us makes it completely; some of us are more lucky than others, and these others are often our callers, are those who need crutches, are those who are not well equipped for coping with life's hardships, for coping happily with responsibilities. If things go wrong, like children, they can have great despairs; when faced with responsibilities, they can feel helpless. They often want to receive rather than to give, and for them the world is often seen as filled with threatening dangers. They need crutches (drugs, alcohol, supporting friends, etc.). They resist when you tell them to be more independent, can feel rage and fear about it ("no one cares for me").

Our society is not equipped technologically and philosophically for successfully coping with and treating many handicapped persons, and we have to be realistic; some people will always remain physically and/or emotionally dependent. As one good result, some other people will find personal fulfillment from caring for such handicapped persons; but in our eagerness to make our callers feel better, we can be dangerously tempted to sustain and encourage dependent needs, as the mother who would let, or even encourage her polio-affected child to watch "happily" the television all day long, instead of firmly encouraging him to do his prescribed exercises. If she lovingly but firmly encourages him to do it, he might react negatively and claim he hates her for it, but this will be for his own good, he will be aware of it, and will not be psychologically affected by such "rough" treatment.

Of course, our callers are not our children, but by calling us, they give us a responsible role. Our message can be one which fosters independency, which encourages them to use or learn to use untapped resources. As with the polio affected child, we will not expect rehabilitation overnight and, if only because of the great limits of a telephone operation, we will accept that our modest intervention is seldom a miraculous one. It can, however, be a positive contribution. We will be goal oriented with dependent callers, study with them what they can practically do for making their lives a bit better, and not encourage them to call again and again unless it is to report on what progress they made toward independence. With a child who has a great despair, you offer first warmth, then you encourage him to do what he has to do. With our callers, we at first can offer much of the milk of human kindness, then we can talk business.

Our final message can be, if only in better and more tactful terms, something like this: "ultimately you might have to face life more on your own, ultimately you will have to think of what you can do for others rather than being pre-occupied by what others can do for you. You may have to learn to live with fewer and fewer crutches. Ultimately, you will have to face more responsibilities and learn to cope serenely and firmly with them. Ultimately, you will have to discover that you can like all that. Ultimately, you certainly can exercise more fully your role as an adult."

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Ron

What Is a Homosexual? A Definitional Model

Brian and Jim were members of the same group but there was a world of difference between them. Brian had been having sex with older men since his early teens but he adamantly denied that he was homosexual; Jim had never had sex with a man but insisted that he was homosexual.

THIS DESCRIPTION of two members of a men's support group illustrates a problem that has received little attention: what defines a homosexual?¹ Until recently, few helping professionals were concerned about this issue. They assumed that homosexual men and women were readily distinguishable by their mannerisms and dress. Causative psychological and biological theories reinforced the notion that homosexuals were clearly different from heterosexuals.² Since the emergence of the Gay Rights movement and greater knowledge about homosexuals, these notions have largely been put aside. From a historical point of view, it is interesting that Kinsey, Pomeroy, and Martin first discussed this issue in 1948:

It would encourage clearer thinking on these matters if persons were not characterized as heterosexual or homosexual, but as individuals who have had certain amounts of heterosexual experience and certain amounts of homosexual experience. . . .

. . . one is not warranted in recognizing merely two types of individuals, heterosexual and homosexual.³

Unfortunately, the prophetic advice was ignored until recently.

Nevertheless, it is important to have a definition. But such a definition must recognize the complexities of

Raymond M. Berger

Social work practice has suffered from a lack of a model to explain what constitutes homosexuality. The author presents such a model and discusses its implications for practice. He contends that the worker must discard the traditional binary model of heterosexual versus homosexual for one incorporating relevant psychosocial factors.

sexual identity if the social work profession is to respond intelligently to the needs of people for whom this issue is relevant. How can these needs be addressed before it is clear whom the target group constitutes? Unless they know what a homosexual is, how can practitioners provide effective services to individuals who may be on the road to a homosexual identity? Moreover, there may be several "kinds" of homosexuals, ranging from those who are inaccurately labeled by peers to those who are firmly committed to a homosexual identity. This article presents a definitional model that may help clarify these issues.

THE MODEL

Paths to Identity

The model summarized in Figure 1 includes two dimensions: time and tasks. The dimension of time is included to indicate that certain subtasks are sequential and that some of them may overlap. For instance, identity confusion always precedes self-

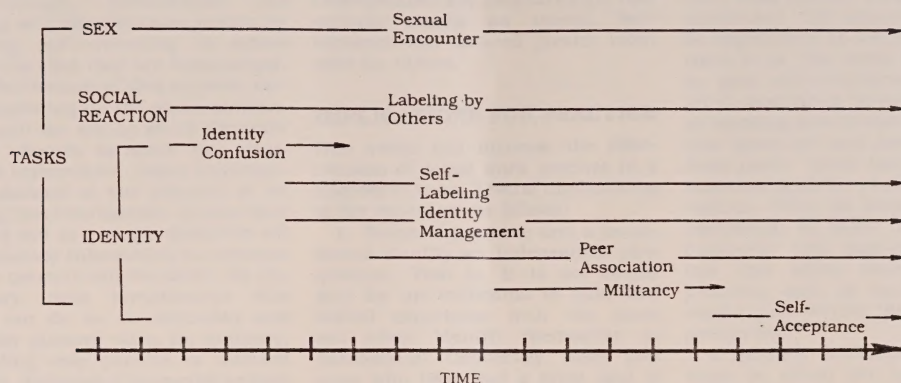
labeling, but these subtasks may operate simultaneously at some point.⁴ The first dimension is composed of three major tasks that occur independently in homosexual identity formation: sex, social reaction, and identity. The task of identity, which is most crucial, is achieved by the completion of a number of subtasks.

Each task and subtask has a specific definition. Sexual encounter refers to physical contact that participants or others perceive as sexual. It includes kissing, genital petting, and intercourse. Research has shown that, under the proper circumstances, an individual can engage in repeated sexual contact with a member of the same sex but not be identified by self or by others as homosexual and that this phenomenon is widespread.⁵ Thus, this task is independent of social reaction and identity formation. Participants use various strategies to avoid being labeled as homosexual. They may define certain sexual acts with a member of the same sex as "heterosexual," for instance, insertion in oral copulation; limit the term "homosexual" to persons with certain characteristics; or reinterpret the situation, using an expression such as "I was taken advantage of."

The importance of labeling by others and its designation as an independent task are based on societal reaction theory. As Becker noted:

. . . social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an "offender." The deviant is one to whom that label has successfully

Figure 1.
A Model for Homosexual Identity Formation



been applied; deviant behavior is behavior that people so label.⁶

Labeling by others is independent of sexual encounter and identity tasks, as is illustrated by an individual with purely heterosexual experience and identity who is erroneously labeled as homosexual. Although labeling by others is an important event and often plays a major role in homosexual identity formation, it is neither a necessary nor a sufficient precursor to such an identity. The individual's perception of how others regard him or her (which may differ from how others actually regard the individual), as well as peer association and intrapersonal factors such as self-labeling, also play a role in homosexual identity formation.

The individual reaches a homosexual identity only after completing a series of tasks or subtasks. Identity confusion is a universal subtask that initiates a chain of other subtasks. Everyone's intrapsychic structure rests on three elements: overt behavior, covert behavior, and self-image. In this model of sexual identity, overt behavior may include sexual activity, association with certain types of persons, and personal mannerisms. Covert behavior refers to elements such as daydreams, fantasies, and sexual attractions. A state of identity confusion exists when two or more of these elements are incongruent. In identity confusion, the individual experiences discomfort, anxiety, or even panic.⁷ For instance, a person whose overt behavior and self-image are en-

tirely heterosexual may be troubled by a recurring sexual attraction to same-sex friends. Within Western and other homophobic cultures, it can be assumed that all individuals who identify as homosexual have experienced identity confusion. Although there is no inherent reason for this state, it becomes inevitable as a result of society's condemnation of homosexual behavior, thoughts, and feelings. Because parents train children from an early age to view themselves as heterosexual and children have no models of homosexual experience, conflicting overt or covert behavior always leads to incongruence and a state of confusion. This is often expressed by the individual as "Why do I think/feel/act this way?"

Changing the Self-Image

The individual who is in a state of identity confusion pushes toward resolution by changing his or her overt behavior, covert behavior, or self-image.⁸ The person who opts for a change in self-image is proceeding further along the road to a homosexual identity by self-labeling, first tentatively ("Am I a homosexual?") and then definitively ("I am a homosexual"). This change in self-image is determined, in part, by how the individual believes others perceive him or her.⁹

At this point, many individuals begin to seek others who have also labeled themselves "homosexual." The individual feels validated by learning that there are many others like him or her and that they are

similar in a variety of ways. The possibility of being a homosexual becomes more plausible. Contact with a homosexual clique or community exposes the individual to a set of norms that counters prevalent hostile social attitudes and legitimates a homosexual identity, as expressed in the slogan "Gay is Good." Often the individual learns a philosophy that justifies the new identity. Such a philosophy may include the belief that homosexuals are born that way or that homosexuals are better than heterosexuals in some ways (that they are more creative, for example).

An individual who labels himself or herself as homosexual must decide how this "new" information will be handled. Since inappropriate disclosure can have drastic consequences, identity management is a crucial task, particularly with friends, family, and employers.¹⁰ The majority of homosexuals invest substantial effort in controlling this information by "passing," that is, playing a heterosexual role to conceal their homosexuality.¹¹ Because outside the gay subculture, people are assumed to be heterosexual, most homosexuals can pass successfully in social situations. However, the possibility of an information leak (for instance, being seen in a gay bar or with someone assumed to be homosexual) is ever present. This threat of exposure constitutes a drain on the emotional resources of many homosexuals. For instance, Weinberg and Williams found that although passing among male homosexuals was not related to most

psychological problems, those homosexuals who passed were more likely to score high on indicators of depression, interpersonal awkwardness, and anxiety about their homosexuality.¹²

Increasingly, homosexuals are dealing with identity management by "coming out"—revealing to others their view that they are homosexual. The effectiveness of this solution varies, depending on the social environment and the way in which the individual chooses to share this once-private information. Some heterosexuals, alarmed at the prospect of receiving this information, assume that coming out is a single definitive act that releases information to everyone in the person's environment. On the contrary, most homosexuals who come out do so in controlled and carefully planned ways, for instance, by telling only parents or selected friends. Although it is possible to pass in most casual interactions, relationships with close friends, family members, and sometimes employers will be strained unless information about the person's homosexuality can be shared without negative consequences.

Some individuals resolve the identity-management problem by releasing information in an aggressive manner in all or most social situations, often through the use of symbols such as gay or lesbian buttons, eccentric dress, or exaggerated mannerisms. These persons have reached the subtask of militancy. In this stage, individuals are vocal about the realities of oppression and tend to see issues in all-or-nothing terms (for example, "All heterosexuals oppress gay people"). Often they have only recently labeled themselves as homosexual. Taking an aggressive stance seems to be a way that these individuals can prove to themselves the very beliefs they are espousing. At times, they reveal their homosexual self-identification even in casual social situations. Unlike the other subtasks in the model, this one is not part of the identity formation process for all homosexuals. However, for many persons, it is a step toward self-acceptance.

Self-acceptance is the final task in a process whose duration may vary from several months to several decades. At this point, the cognitive elements of overt and covert behavior

and self-image are congruent, and the individual has fully integrated the concepts of "me as a good person" and "me as a homosexual." Comfortable with this identity, the individual can take a less defensive posture toward heterosexuals and may no longer take extreme stands on issues. Self-tolerance has fostered greater tolerance for others.

IMPLICATIONS FOR PRACTICE

This model can increase the effectiveness of social work practice in a number of ways. Several implications of the model are as follows:

1. Sexual experience and a homosexual identity are independent phenomena. That is, it is not necessary for an individual to have had sexual experience with the same sex never identify themselves as homosexual. Conversely, many persons who have had a great deal of sexual experience with members of the same sex never identify themselves as homosexual. Social workers often mistakenly assume that clients' homosexual feelings are "irrational" or are not a "true" indicator of homosexuality if the clients have not had an actual sexual experience. Since many, if not most, of these clients will eventually form a homosexual self-identity, this practice is harmful. It merely prolongs the process leading to self-acceptance. Social workers also frequently assume that a client is a "latent" homosexual on the basis of sexual experiences that the worker but not the client labels "homosexual," which is another harmful practice.

2. Being labeled homosexual by others also is independent of a homosexual identity. Individuals who are labeled as homosexual may or may not think of themselves as homosexual. Social workers should be sensitive to this issue, especially when working with adolescents, for whom peer influences are great and self-identity is in flux. It is interesting to note that the individual who is merely labeled homosexual may have the same problems in controlling this information as an individual with a homosexual self-identity. Thus, laws and policy that protect against discrimination on the basis of sexual orientation benefit all those who depart from sex-role norms or who are inaccurately labeled, whether they

think of themselves as homosexuals or as heterosexuals.¹³

3. There are many ways to be a homosexual. A client receiving social work services may be in any one of several phases of identity formation, from identity confusion to self-acceptance. The intervention should be appropriate to the stage that the client is in. The model suggests that to gain self-acceptance, the client must accomplish certain tasks, such as learning how to manage information about self and deriving support from peers. These tasks can be appropriate goals for professional intervention. With its emphasis on the completion of tasks, this model is consistent with task-centered practice and other social work approaches, and, as such, should fit comfortably within the social work perspective.¹⁴

4. Identity confusion—the initial stage in which the individual perceives certain information about self that is incongruent with the current self-image—is a time of unusual stress. It is not surprising then, that clients frequently seek professional help at this time. Identity confusion most often occurs in late adolescence or early adulthood, although it may occur in middle age.¹⁵ The task of intervention is to make the client aware of the incongruence between ways of acting, thinking, and feeling and the client's self-image. Overt behavior may be changed, but covert behavior, such as dreams and sexual feelings, is more difficult to alter. The worker can explain the process of becoming a homosexual, as indicated in the model; on the basis of this information, the client can decide if he or she would like to change. When parents or significant others are involved, explaining this process can also alleviate unrealistic anxieties and help the parents to decide what they would like for their child. In any case, the ultimate goal of intervention is self-acceptance.

5. If the client has decided to adopt or retain a self-definition as a homosexual, the worker can help the client to work through the tasks that are prerequisites of self-acceptance. Two important and related tasks are learning how to handle the information that one is homosexual (identity management) and finding support among peers (peer association). Common identity-management ques-

tions concern how much and in what manner information should be shared with parents, heterosexual friends, and employers. The worker can play an important role in helping the client plan strategies to reveal this information and can serve as a mediator between the client and individuals and groups who will be receiving the information.¹⁶ Peer association facilitates identity management too because other homosexuals are an important source of information about ways of revealing oneself, as well as of the likely consequences of disclosure and how to handle them. Peer association is vital to self-acceptance in that it makes available a reference group that provides the individual with positive evaluations of being homosexual. The social worker can help the client learn the skills necessary to meet and interact with peers and provide the impetus for self-help groups.

6. Many clients pass through a stage of militancy that is characterized by the need to assert their homosexuality. The model suggests that this is not a pathological state but, rather, a necessary prerequisite of self-acceptance for many individuals, and it should be viewed as such by practitioners.

CONCLUSION

A homosexual identity is the result of a system of interacting influences that include life experiences, cultural and religious values, social reaction, self-attribution, and association with others. In addition, the social definition of homosexuality as well as its self-attribution may change over time or over the course of an individual's life. Taking these complexities into account, the social worker must discard the traditional binary model of heterosexual versus homosexual in favor of a model that incorporates relevant psychosocial factors. The model that has been presented by the author in this article takes a step in that direction.

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Realities of Gay and Lesbian Aging

Raymond M. Berger

IN RECENT YEARS the social work profession has directed attention to the special needs of men and women who are homosexual.¹ However, almost no knowledge has been available to social workers about the needs of a group within the gay and lesbian community that is most vulnerable to social, economic, and psychological forces and, therefore, most likely to come to the attention of social workers. This is the group of older gays and lesbians, people aged 40 and over, who, by conservative estimate, number one and three-quarter million persons in the United States.² The purpose of this article is to report findings from in-depth interviews with eighteen older homosexuals in a preliminary attempt to identify the characteristics and needs of this group.

In the absence of research and public discussion, misinformation and stereotypes about older gays and lesbians have thrived, even among social work professionals. Although the gay rights movement has helped in part to counter inaccurate information about homosexuality, the reluctance of older gays and lesbians to participate in that movement has perpetuated a shroud of ignorance about homosexuals who are older. Some common stereotypes are that the older homosexual has no family ties and few friends, is isolated from other homosexuals, is depressed and unhappy, seeks sexual gratification from children, and with age becomes increasingly effeminate (in the case of men) and increasingly cold and cruel (in the case of women).³ The author's study examined those notions and identified the unique needs, as well as strengths, of older gays and lesbians.

SAMPLE AND METHOD

The study defined an older homosexual as any individual who was self-

Social workers have little accurate information about older gays and lesbians. This article presents the findings of an interview study of 18 homosexual men and women aged 40 to 72. The author makes recommendations about the provision of social services to this group by professionals and peers.

identified as gay or lesbian and who was 40 years of age or older. The age of 40 was chosen on the basis of research among homosexuals that indicated there was universal agreement that a person of this age was no longer young.⁴ Respondents in the study ranged from 40 to 72, with a median age of 54. (See Table 1.)

Drawing from the small available literature on this group and discussions with older homosexuals, the researchers designed an interview schedule, pretested it, and modified it for clarity.⁵ All questions were open-ended and covered the following topics: social life, involvement with the homosexual community, involvement with family, love relationships, "coming out," sex life, intergenerational attitudes, discrimination, and perspectives on growing older.⁶

The study was carried out in an urban area with a high concentration of the elderly. The author and a female research assistant located respondents through announcements

at meetings of homosexual organizations and through placing advertisements and articles about the study in newsletters of homosexual religious and political groups. To reach men and women who did not frequent these organizations, each older person enlisted for the study was asked to recruit older friends who did not attend activities in the homosexual community. These friendship networks contributed six older respondents.

A word about the sample is in order. For both conceptual and logistical reasons, no research on homosexuality has achieved a representative sample. Conceptually, a representative sample has not been possible because of the absence of a clear definition of homosexuality.⁷ The presence in this study of several respondents who had lived either as heterosexual or homosexual liberated at some points in time attests to this problem. Therefore, for this study the self-attribution of homosexuality was chosen as the most valid definition. From a logistical viewpoint, research samples of homosexuals have been biased in favor of white, affluent, well-educated respondents due to problems of recruitment; despite efforts to recruit minorities, this study was no exception.⁸ Although occupational status ranged from low (stock clerk) to high (bank president), all respondents were white. Demographic characteristics of the respondents are presented in Table 2.

Another sampling limitation was the bias in favor of homosexuals who had participated in at least one gay or lesbian community organization. These homosexuals were more accessible to the author but may be atypical of the population as a whole. It is noted, however, six of the eighteen respondents did not participate in homosexual organizations, while the

hances the representativeness of the sample. Nevertheless, it is probably the case that a truly representative sample would have included an even greater proportion of respondents who were not participants in homosexual organizations. Therefore, one should not assume that the results of this study apply to all older homosexual men and women.

A final sampling issue, which was recently brought to light by a noted researcher of homosexuality, concerns the refutation of stereotypes.⁹ Because stereotypes are by definition universal hypotheses about populations, any members of the population who do not correspond to the stereotype challenge it. A biased but diverse sample of the population is sufficient to refute stereotypes, as long as the findings are not interpreted as demographic representations of older homosexuals in general.

Interviews—conducted by the author (a male in his late twenties) and by a female research assistant in her mid-forties—took place in respondents' homes, at a university office, and in other settings such as a bar. To maintain the natural flow of the interview, which lasted from one and one-half to two hours, the order of topics was usually determined by the respondent. All interviews were tape-recorded with the respondents' permission.

'COMING OUT'

Although recent research has shown that homosexuals and heterosexuals are more alike than has been commonly assumed, homosexuals experience a unique life event, usually in their adolescent or early adult years.¹⁰ This is the process of "coming out," of beginning to think of oneself as homosexual, which has an impact on self-concept and personal adaptation, as well.¹¹

All the interviewees felt that coming out was one of their most significant life experiences. Because definitions of coming out vary, the interviews began by asking, "What does coming out mean to you?" Three related definitions emerged: Certain respondents believed that coming out referred to the first sexual encounter with a person of the same sex. Others felt it referred to revealing one's homosexuality to others. These might include only family or close friends or

Table 1.
Characteristics of Older
Homosexuals (N = 18)

Characteristics	n
Sex	
Male	10
Female	8
Living Situation	
With a lover	12
With a roommate	4
Alone	2
Marital Status	
Never married	9
Divorced or separated	7
Currently married	1
Widowed	1
Number of Children	
None	10
One	2
Two	5
Three	1
Job Status	
Not retired	9
Fully retired	7
Partially retired	2
Religion	
Protestant	14
Catholic	2
Jewish	2

might extend to the general community. The third definition focused on self-recognition and self-acceptance. As expressed by one woman in her mid-forties,

Coming out means giving in, becoming, your sexuality. It means feeling good that you are gay, not feeling you are something you shouldn't be, not caring. It is the most beautiful thing in the world.

With one exception, all respondents went through a lengthy and usually painful process of self-doubt before finally accepting their homosexuality. One woman in her early forties recalled an unhappy marriage and a struggle of many years: "I knew I was attracted to women, but I didn't know what was wrong with me." Only after the birth of a child and her husband's death did she pursue relationships with women. A man in his fifties described his reaction to the realization that he was gay thus, "I felt like there was a constant threat over me. I could be caught at any moment. I knew what I wanted, but I didn't feel comfortable pursuing it."

These findings illustrate the complexity of coming out and establishing a homosexual identity. This process involves a number of elements—awareness of same-sex arousal, sexual experiences, reactions of others, and self-concept as a homosexual—that often interact from early adolescence into old age. For instance, several respondents engaged in sexual behavior with members of the same sex for many years without regarding themselves as homosexual; other respondents claimed that they knew they were homosexual from an early age, even in the absence of actual sexual experiences. To add to this complexity, not all gays and lesbians experience the same aspects of coming out or experience them in the same way over time. However, despite the complexity of describing coming out, the present study did ask respondents to identify two specific components of the process in themselves.

The first question asked respondents to describe their initial sexual experience with a person of the same sex. One of the most prevalent misconceptions about homosexuality is that young persons are seduced by older persons. However, only three of the respondents (all male) had had an early sexual encounter with an older adult, and in two of the three instances the respondents had been willing participants. All other first same-sex partners were peers, most commonly school buddies. The men had had their first homosexual experiences at a younger age than the women (a finding that agrees with other studies of differences between homosexual males and females).¹² All the men except one had had their first homosexual experience by the age of 17, whereas the women had not had their first experience until their late teens or their twenties.

The second question asked the respondents to remember when they had first realized that they were attracted to members of the same sex. By the age of 27, all the men and women had realized they had had this attraction, with all but two coming to this realization by their early twenties. Although self-reported data are subject to respondents' inaccurate recall, most respondents associated their early same-sex feelings with particular experiences and relationships that fixed those experiences in time.

COMMUNITY

Association with other homosexuals is an important part of self-acceptance. Not only does it relieve the sense of being "the only one in the world who is different," it also exposes the individual to a set of beliefs that counter prevalent negative social attitudes.¹³ Most of the men and women interviewed began to meet and socialize with other homosexuals around the time that they recognized their own homosexuality, in late adolescence or early adulthood; however, there were four notable exceptions. Two men and two women had heterosexual marriages from early adulthood to middle age, at which time they decided to abandon their spouses in favor of homosexual relationships. (Two of these respondents were in their forties, one was in her late fifties, and one was in his sixties when this decision was made.) All these individuals had been aware of homosexual feelings early in life, yet, in response to social pressures and from lack of self-awareness, chose heterosexual lives and in fact had had no homosexual contact for as long as thirty years. Ultimately, their heterosexual lives proved unsatisfying. There are no data on the number of individuals who change sexual orientation late in life, but the presence of four such persons in this study suggests that the common assumption that such choices are always made early in life is not accurate. Social workers need to be aware of the existence of this phenomenon.

As noted earlier, one popular misconception about older homosexuals is that they are isolated from both heterosexuals and other homosexuals. In fact, none of the respondents in the present study fit this stereotype. In most urban areas, a variety of places are available for homosexuals to meet. These generally fall into two categories: (1) those primarily oriented to sexual contact, such as bars, bathhouses, and "cruising areas" in parks and at beaches, and (2) those oriented to social, civic, or religious purposes, such as gay rights organizations, social clubs, and gay churches. Both of these types of settings are dominated by younger men, but the civic and particularly the religious organizations have attracted many older homosexual men and women.

All but six of the respondents (four men and two women) participated in a civic or religious organization, with the gay churches being the most popular. The sexually oriented settings revealed a different pattern, with all but two of the men and none of the women frequenting them. The social worker serving older homosexual clients should be aware of the resources available for meeting others, and the differential use of these resources by men and women.

The degree of support that older homosexual men and women derive from other homosexuals has been underestimated.¹⁴ All the respondents spent at least half their social life with other homosexuals and five men and two women socialized exclusively with other homosexuals. A common pattern was the presence of two sets of friends: a heterosexual set associated with work or business and a homosexual friendship clique.

LOVE AND FAMILY

Homosexuals, like heterosexuals, usually strive to meet social and sexual needs by coupling with another individual. In the homosexual community, that individual is called a lover and generally shares a home and a social and sex life with the partner. At the time of the interviews, all the women and five of the men had a lover, with the length of the relationships ranging from six months to eighteen years. Most had been together for several years. Given the small size of the sample, it is impossible to conclude that lesbians are more likely than homosexual men to maintain long-term relationships, although some of the literature suggests that lesbians are more oriented to personal relationships than are gays.¹⁵ Although five of the men were without a lover at the time of the interviews, all the men except one had had a lover in the past, in many cases for years. The one man who had never had a male lover continued in a heterosexual marriage of thirty years while pursuing sexual contacts with men. Several of the men and women followed a pattern of love relationships that among heterosexuals has been described as serial monogamy, that is, a succession of sexually exclusive relationships. In any event, social workers serving this group would be wrong to accept the

stereotype of older homosexuals as loners.

The respondents were sexually active people. All reported having sex at regular intervals ranging from once every other month to daily (except for one man in his seventies who was incapacitated by surgery). When the respondents were asked how their sex lives differed now from when they were younger, an interesting contrast emerged between the men and women. The men consistently answered in terms of the frequency of sexual activity, whereas the women answered more often in terms of the quality and interpersonal aspects of the situations. Five men and four women said that they were less sexually active, whereas two men reported more sexual activity. Several men and women stressed that sex was more meaningful to them now, even if it occurred less often.

Six of the men and six of the women said that they were satisfied and—in some cases very satisfied—with their current sex lives. All those who had a lover maintained regular sexual relations with the lover, except for one man who had terminated sexual relations with his lover and sought brief sexual relationships with younger men. Among the men with lovers, sexual monogamy was not the rule; among the women it was strictly followed.

Despite recent efforts by some conservative groups to link homosexuals with the dissolution of families, homosexuals do have many family ties. Most of the respondents had regular contact with family members, including parents, siblings, and, in the case of those who had been married, children. Some of the respondents had openly discussed their homosexuality with family members; others had never discussed it but assumed that family members knew about it. Some had kept it a secret until their parents' death or were no longer close enough to surviving family members to make it worthy of discussion. In some instances, family members had been highly supportive: One mother had attended her son's holy union to another man at a gay church; one younger sister had served as a confidant; and one son had supported his 65-year-old father in the decision to leave his wife to live with another older man.

Some parents had pressured the re-

spondents to marry many years earlier, and three respondents had experienced severe social and emotional consequences because of unsupportive family members. One male respondent's wife, in response to her husband's relationship with a man, had informed her husband's employer. Two of the women had endured lengthy legal battles initiated by parents who, on learning of the respondent's homosexuality, had sought custody of the children. Although an extreme reaction by family members is atypical, it illustrates the vulnerability of homosexuals to severe social consequences.¹⁶

INTERGENERATIONAL ATTITUDES

A recent study by the author found that older homosexual men with many younger friends adapted more successfully to aging than did those without younger friends.¹⁷ In light of this, the present study assessed respondents' beliefs and attitudes about younger homosexuals. The majority (five men and five women) believed that younger homosexuals held negative attitudes toward their seniors. Such remarks as the following exemplify this belief:

Young gays feel about old gays the same way I felt about them when I was young. They are relics. They're worn out.

Young gays are bored by us. They're not interested in inviting us to join along.

A minority believed that age was not a barrier to arousing the interest of younger homosexuals, as indicated in the following:

There is a curiosity about older people. [Younger people think.] "Gee, you lasted a long time, maybe we can too."

Eight respondents believed that negative perceptions of young homosexuals are prevalent among older homosexuals. One older lesbian epitomized this attitude:

I think young gays are fine for each other. For myself I don't find too many young people hold my interest. I find them superficial

and selfish and I'm not willing to give too much of myself.

Other respondents enjoyed the company of younger homosexuals and some actually preferred them to their elders:

The younger gays are more honest and open about who they are.

They look up to me as someone they can learn from.

DISCRIMINATION

Older homosexuals are particularly vulnerable to unfair discrimination because they are jeopardized twice: once for being homosexual and again for being older. Therefore it is not surprising that half the respondents described instances of discrimination in employment, housing, and child custody. Several had experienced multiple instances of discrimination relating at certain times to age and at other times to sexual orientation. For instance, one woman lost her son after a lengthy court battle in which the judge decided that, as a lesbian, she was an unfit mother. Years later she was denied a sales job on the grounds that a younger (and presumably more attractive) woman would have greater success with male customers. Three men had been court-martialed for homosexual acts while serving in the army in the late 1940s and 1950s. One man in his sixties described the irony of primarily worrying about the consequences of others learning of his homosexuality, only to discover that he was repeatedly turned down for jobs because he was too old. The prevalence of discrimination in this sample, given its small size, is striking. More attention needs to be paid to this issue.

GROWING OLDER

The men and women in the study represented a special resource for understanding the process of aging for homosexuals. Their responses to the question, "What makes a gay man or woman adjust well to growing older?" provided insightful suggestions.

Respondents repeatedly stressed that adaptation to aging was no different for heterosexuals and homosexuals. As one older man expressed

it, "A person who hasn't adjusted well to other aspects of life won't adjust well to aging either. Being gay is just the icing on the cake." An older lesbian said, "Being old is a state of mind. It has nothing to do with sex preference."

A sense of security—crucial to successful aging—can be fostered by developing interests outside of work, by maintaining friendships and family relationships, and by putting money away to guarantee a secure retirement. Several respondents advised associating with people of all ages, lending credence to the finding that socializing with younger people is associated with successful adaptation for this group. By doing this an older person will keep up with new ideas and be stimulated to change and develop. Attitudes toward aging itself were seen as crucial. It is important to accept the limitations of decreased physical stamina rather than to try to fight them, but at the same time, it is crucial not to dwell on one's increasing age. As one man expressed it, "Tear the calendar off the wall."¹⁸

An important prerequisite for successful aging suggested by the respondents was the development of self-awareness. First, the older person must transcend his or her own immediate concerns or, as one respondent said, "Don't make the assumption that you are the center of the universe. Learn to get out of the spotlight." Second, the older person must come to accept him- or herself, which means truly coming to terms with a homosexual identity. One lesbian in her late fifties described the process of accepting her homosexuality:

Before the last couple of years, I felt dejected, like I was ready for the rocking chair. Since then I have been more or less in the "homosexual community of thinking" and I've felt a new lease on life. I can finally be me.

Respondents talked about some of the worst aspects of growing older. Facing one's mortality—the realization that one can never recover lost time—was mentioned frequently. One man reflected, "You suddenly realize that your time is limited. It's like being forced to leave a party before the other guests." Many respondents mentioned problems of poor health or body changes: the loss of one's

senses, pain, limitations in physical activity, and lack of energy. Poor finances in retirement were also a major concern. These concerns are the same as those experienced by all older persons; the data on growing older, like the data on love relationships and family, suggest that older homosexuals have much in common with older heterosexuals.¹⁹

The older men and women in this study also talked about the joys of old age. One advantage of being older is that one has made all the mistakes and learned from them. One has a certain wisdom that others recognize. Friends seek advice, listen, and afford the older person special privileges. Several respondents said that they were relieved because all the battles were behind them; as one man stated, "I've gone through all that, and thank God I don't have to face it again." Better self-understanding, less worry about what others think, and more self-confidence were some other rewards of aging, as was the ability to reminisce about past good times.

FINDINGS AND RECOMMENDATIONS

The major finding of this study—that stereotypes about older homosexuals are not accurate—signals the need for social workers, especially those serving older persons, to become aware of the realities of homosexual aging. As discussed earlier, because twelve of the eighteen respondents were recruited through religious and political organizations, this study was less likely to include the isolated older person. Nevertheless, the lives of the men and women in the study challenge the stereotype of the older homosexual as isolated and depressed. Although the social recluse does exist, this study suggests that most older homosexuals function in networks of friends, lovers, family, and community institutions. Social workers should use these networks as resources in interventions on behalf of older homosexuals. In almost every urban area, the gay and lesbian community offers settings that may be used by older homosexuals, although social workers must become aware of which settings welcome older persons and which do not. Resource development for older homosexuals is an important activity in which a few social workers have been involved.²⁰

“ Association with other homosexuals is an important part of self-acceptance. ”

Most older gays and lesbians prefer to associate with peers of a similar age and have active sex lives with age-appropriate partners. The quality of the older homosexual's sex life with a lover is just as vital to a homosexual couple as it is to a heterosexual couple. Some homosexuals, however, especially those who are more open about revealing their sexual orientation, prefer to associate with younger homosexuals. They should be encouraged to do so, because such association may help these individuals in adapting to aging.

Discrimination in housing and employment is a major problem among older homosexuals. There is a need for case advocacy as well as legal and policy changes, all of which activities are appropriate for social work.

Although a comprehensive consideration of how social services should be organized to meet the needs of this group is beyond the scope of this article, the author would like to raise three questions that must be addressed: (1) Who should organize and staff social services for older gays and lesbians? (2) What kind of services should be offered? and (3) How can social workers be sensitized to the needs of older homosexuals?

Should services be offered by professionals or by lay persons; by homosexuals or heterosexuals?; by young and old or by peers of a similar age only?

It seems to the author that trained professionals have a great deal to offer and that their skills ought to be applied to developing and improving services for older gays and lesbians. It is also the case that peer services for older persons have enjoyed great popularity and apparent success, as exemplified by programs such as the national Retired Senior Volunteer Program. There is certainly truth in the idea that "those who have been there" are best able to serve their peers.²¹ Yet another advantage to service by peers is that it also offers something to the service provider. For many older homosexuals, it offers an important social role to replace

roles lost because of retirement and the deaths of friends and significant others. For the older homosexual in need of services who finds it difficult to relate to younger persons, the older peer may be the best answer.

This does not mean, of course, that younger people—professionals and nonprofessionals—do not have a role. Younger persons ought to be involved—after all, they will eventually join the ranks of older persons—but there is a tendency for younger persons to dominate the leadership. For this reason, one organization of homosexual men in San Francisco excludes individuals under 40 from regular membership (although it involves them in some activities). As services for older gays and lesbians emerge, the issue of control will be important. A challenge for those organizing such services will be the active participation of older persons, not only on advisory boards, but in the day-to-day decision making of the groups.

The issue of heterosexual participation raises the much-discussed question of integrated versus separatist services.²² It is the author's observation that homosexuals are experiencing in the 1980s what blacks and other minorities learned in the 1960s: No one else seems able and willing to provide the kind of services needed. Mainstream agencies have simply not recognized the existence of older gays and lesbians, much less directed programs to their needs, and recent cutbacks in social services spending make it less likely that they will do so in the near future. It is not surprising, then, that the professionals and nonprofessionals involved in organizing services for older homosexuals have generally been homosexual themselves and that this will probably continue to be the case.

What kinds of services are needed by older gays and lesbians? The author's research suggests that they need the same services as all older adults: health care, income maintenance, transportation, social and recreational outlets, and emotional support. Many older homosexuals cur-

rently receive and benefit from these services. But service providers need to be better informed and more sensitive about the unique situation of older homosexuals. For example, how many social workers are ready and able to help a middle-aged or older person in the transition to a newly acquired homosexual identity, a phenomenon that occurred to four out of eighteen respondents in this study. How many friendly visiting services would be able to respond to a client's request for a gay visitor?

Social workers can only be sensitized to the needs of older gays and lesbians through exposure and information. More comprehensive descriptive research is needed to find out the characteristics and needs of this group, and this research, as well as the small amount of research currently available, must be publicized and receive the attention of professionals, particularly those who work with the elderly. Professionals themselves need to be exposed to older homosexuals. Panel presentations, speeches, and workshops that include older gays and lesbians who are open about their sexuality need to occur in agencies serving older persons. This requires, of course, that older homosexuals themselves become more assertive about their right to be served with dignity.

According to the men and women in this study, the issues involved in adaptation to aging are essentially the same for heterosexuals and homosexuals: need for activities, friends, and sufficient finances, and concerns about health and sexuality. An additional element for older gays and lesbians is acceptance of themselves as homosexuals, an acceptance that is sometimes not fully integrated until later in life. As more information becomes available about older homosexuals, this process will be facilitated.

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Notes and References

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3. Several authors have discussed the prevalence of stereotypical beliefs about gays and lesbians on the part of professionals and nonprofessionals. See, for example, Berger, "The Unseen Minority"; and James J. Kelly and Myra T. Johnson, "Deviate Sex Behavior in the Aging: Social Definitions and the Lives of Older Gay People," in Oscar J. Kaplan, ed., *Psychopathology and Aging* (New York: Academic Press, 1978).

4. Fred A. Minnigerode, "Age-Status Labeling in Homosexual Men," *Journal of Homosexuality*, 1 (Spring 1976), pp. 273-276.

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6. A copy of the interview schedule is available from the author.

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12. Marcel T. Saghir and Eli Robins, *Male and Female Sexuality: A Comprehensive Investigation* (Baltimore, Md.: Williams & Wilkins, 1973), pp. 211, 218-220.

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14. Kelley and Johnson, "Deviate Sex Behavior in the Aging."

15. Bell and Weinberg, *Homosexualities*.

16. Raymond Mark Berger, "An Advocate Model for Intervention with Homosexuals," *Social Work*, 22 (July 1977), pp. 280-283.

17. Raymond M. Berger, *Gay and Gray: The Older Homosexual Man* (Urbana: University of Illinois Press, 1982).

18. These adaptive tasks are similar to those faced by older heterosexuals. See Robert C. Atchley, *The Social Forces in Later Life* (Belmont, Calif.: Wadsworth Publishing Co., 1977), pp. 214-216.

19. A representative cross section of elderly persons in the United States reported a similar set of problems. See Lou Harris and Associates, *The Myth and Reality of Aging in America* (Washington, D.C.: National Council on Aging, 1975); see also Atchley, *The Social Forces in Later Life*, pp. 207-208.

20. Social workers have been involved in the development of social services for older homosexual men and women in Los Angeles, Miami, and New York City. One of the most successful organizations is Senior Action in a Gay Environment (SAGE) in New York City. The National Association of Lesbian and Gay Gerontologists is based in San Francisco.

21. For a description of SAGE, a peer-oriented service group for older gays and lesbians, see Berger, "The Unseen Minority," p. 240.

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The Coming-Out Process for Lesbians: Integrating a Stable Identity

COMING OUT as a lesbian in the 1980s is a different process than it was 20 or 30 years ago. With the advent of the "sexual revolution" of the 1960s, feminism, and gay liberation, social roles for women have broadened. Attitudes toward being "different" and tolerance for alternative lifestyles have increased among many people. In 1974, the American Psychiatric Association removed the definition of homosexuality as an illness from its diagnostic manual.¹ In the years since, social workers and mental health professionals have needed to understand more about lesbians, but, because lesbians are both hidden and invisible as a population, it has been difficult to gather accurate information. In the 1930s, 1940s, and 1950s, identifying oneself as a lesbian and feeling good about that identity were arduous and sometimes impossible tasks. In recent years, it has become possible for some women to "come out of the closet" by going through several periods of development that integrated their lesbianism into a healthy self-concept. In this article, a model is presented of the process a woman goes through in developing a healthy, well-integrated lesbian identity.

Before undertaking this process with a client, a worker needs to examine himself or herself—to assess personal biases and comfort with homosexuality and to ascertain whether his or her own conditioning and feelings will interfere with providing good services. As Potter and Darty explain,

to be effective in casework with lesbian clients, social workers must become knowledgeable of and comfortable with lesbianism as a sexual preference and life-

Lou Ann Lewis

Social workers have lacked models for understanding the process of a client's self-identification as a lesbian. This article describes several developmental phases a woman may go through to form a healthy self-concept as a lesbian and discusses practice implications for this process.

style. Social workers must recognize that heterosexist society (one governed by both heterosexual and sexist norms) has shaped their perceptions of this sexual orientation. . . . Social workers who cannot accept lesbian clients unconditionally will be destructive to their clients' personal growth.²

LITERATURE REVIEW

Three articles have addressed the coming-out process in homosexuals. Cass describes a six-stage process that applies to both gay men and lesbian women.³ The stages begin with identity confusion and move to identity synthesis. Lehman presents a five-stage model similar to Cass's but applicable only to lesbians.⁴ Although it describes the process, it is not a competence-based model. Neither Lehman nor Cass describes possible social work interventions for the stages. Grace presents a competence-based

model of development for gay men and addresses clinical issues for the stages.⁵ However, he deals exclusively with gay men, and there are significant differences for lesbians in the coming-out process.

Several books on lesbianism include descriptions of the coming-out process or various aspects of forming a positive lesbian identity, the most extensive and relevant of which is Lewis's *Sunday's Women*.⁶ This contemporary book, written for the lay reader, discusses lesbian identity formation at length and presents excellent material on lifestyle, politics, and relationships. However, although Lewis's and other popular books present valuable material, they are more anecdotal and descriptive than clinically oriented.

BEING 'DIFFERENT'

Awareness of being different may start as early as age 4 or 5. For the young girl, this awareness may manifest itself as a sense of "knowing she is somehow different." She may be able to verbalize this difference as a child, or only in retrospect, or not at all. For some women, this feeling stays below the level of awareness until adolescence or into adulthood. Because our society and its process of socialization do not include a positive vocabulary for same-sex attractions (whether emotional or erotic), many girls experience only vague, undefinable feelings of "not fitting in." If the feelings are definable, they are associated with words like "queer" and "homo," are explained away as "just a phase," and, during adolescence, are often denied or sublimated in an attempt to conform. For a young girl who cannot deny her attractions, childhood—

and especially adolescence—may be periods of isolation and withdrawal, and she may wonder, "What is wrong with me?" She may be teased mercilessly by others. A young woman's sense of not fitting in may promote self-blame and self-hatred.

A social worker will rarely encounter a client dealing with this awareness who can verbalize what is going on within herself. It is important to wait for cues from the client before initiating some gentle exploration. A worker need not phrase questions in terms of sexual preference but might ask, "Who have you ever felt close to?" or "With whom have you had important relationships in your life?" If the client's answers reveal significant relationships only with women, the worker could explore further with questions such as, "Are you aware that all your important relationships have been with women?" "How do you feel about that?" A variety of responses from the client are possible, some of which may lead to further exploration of same-sex feelings and some may not. As a general rule, digging and probing extensively can be frightening to the client during this time. Thus, waiting for cues and discussing the woman's anxiety as it emerges are more appropriate.

'DISSONANCE'

As a woman connects her sense of being different with same-sex feelings, she begins to have words for her struggle. During adolescence and young adulthood sexual feelings emerge. At this time a woman may become aware that her strongest emotional and erotic feelings are in relation to women rather than men. Acknowledgment of the sexual element of being different is often accompanied with feelings of denial, shame, anxiety, and ambivalence. This is a time of great dissonance and inner turmoil. A woman faces a conflict between the process of socialization, which teaches her that she will probably marry and have a family, and her feelings, which pull her toward wanting intimacy with other women. This was aptly described by a client as having two choices: "You can be in conflict with yourself and in harmony with the world, or in harmony with yourself and in conflict with the world." Also, the woman's feelings conflict with family values and expectations, add-

ing to the anxiety and shame. In her article on developing a positive gay identity, Berzon poignantly describes her feelings at this stage:

I felt . . . the loneliness of alienation from the true self, as if deep in one's center there is a truth pleading for acknowledgment but lost in denial and dread of exposure to the unknown. Risking the acknowledgment of my gay feelings, the expression, the being known for what is true and so long denied, had been terrifying for me.⁷

With acknowledgment of her same-sex feelings, a woman may begin a grieving process that resembles Kübler-Ross's stages of dealing with a loss.⁸ The woman may show signs of denial and of bargaining with herself. She may say or think, "I feel close and attracted to one woman; that doesn't mean I'm a lesbian." Or, she may refuse to admit to others or to herself any same-sex attractions. Bargaining comes with many rationalizations. She may say or think things such as "Because I'm married, I can't be a lesbian" or "If I'm a nun, I'm certainly not a lesbian" or "I know I want to have children, so that must mean I'm not a lesbian." During this time, both denial and bargaining are used to lessen the dissonance experienced and can be effective in keeping a woman from acting on her feelings. Unlike typical grieving, however, coming out means choosing to move from a socially accepted identity to a socially stigmatized one, so this progression may be accompanied with shame and anxiety. A woman may be terribly afraid of the consequences of being found out and may try to hide her feelings. This concealment may add to the shame she already feels about same-sex attractions. Unlike groups whose minority status is immediately visible, such as racial minorities, in which parents may teach their children skills for coping in a hostile world, a woman with emerging same-sex feelings has not learned these skills and is not supported by her family. Some anger may be experienced at this time, but often it is turned inward, with the woman thinking she is "bad" or "wrong." Wolf describes the pain of same-sex awareness clashing with cultural norms:

many women describe the process of gradually realizing they were

lesbians in isolation, of feeling that because of a lack of role models they were the only one in the world "like this" and of finally coming upon medical or psychoanalytical literature reflecting the norms of the larger culture in which a "scientific" description of homosexuality could only depress them and cause them deep anxiety.⁹

Continuum

For some women in their twenties, thirties, and forties who identify strongly as feminists and who were formerly heterosexual, the early phase of coming out may be different. In their important study of sexual feelings, behavior, and fantasies, Kinsey and his colleagues developed a six-point continuum as a way to illustrate the range of same-sex/opposite-sex feelings and attractions.¹⁰ With 0 as exclusively heterosexual and 6 as exclusively homosexual, Kinsey and his colleagues studied the histories of a large sample population and rated their responses on this continuum. Results showed that the bulk of the population is a mix of same-sex/opposite-sex erotic responses and fantasies.

Many women who would fall in the mid-range of Kinsey's scale do not have a sense of being different as strongly as those closer to the exclusively homosexual end. Because of strong socialization to become heterosexual, a woman in the mid-range may fit fairly easily into a heterosexual lifestyle. She may marry and have children, yet feel something is missing. At some point, her feelings of attraction or her political beliefs may lead her to exploring same-sex attractions. If feminism becomes central to her life, she may use political values such as having an egalitarian relationship and personal independence as an ideological framework for her explorations.

Many feminists in Kinsey's mid-range who are choosing to identify as lesbians in the 1980s might have been fairly well-adjusted heterosexuals in the 1930s or 1940s. Changes in the social environment and the increasing emphasis on liberation and personal growth provided these women a less hostile and frightening atmosphere in which to try new kinds of relationships. These women are spared some of the internalized self-hatred that many exclusively lesbian

women cannot avoid. They have often been spared the struggle of having a profound sense of being different, of being ostracized, and of experiencing the resulting isolation. Because they have formerly fit into expected roles and lifestyle choices, these women may begin the coming-out process with more self-esteem. Being heterosexual gives a woman cultural and family validation that is not available to her otherwise. According to Schaeff, "We are taught that once we attach ourselves to a male, we can get validation and approval."¹¹ A woman who has been heterosexual may have more freedom to explore same-sex feelings with less suspicion from friends and relatives regarding her sexual preference. Although she will still experience dissonance and shame, starting the process with more self-esteem may aid her in moving more easily toward self-acceptance than a woman who has always felt different.

Inner Conflicts

Many clinical issues can emerge out of feelings of dissonance. Because of inner conflicts, a woman may be full of contradictory feelings and fear. This may be evidenced in an aversion to discussing lesbian feelings or in an extremely strong reaction (anger, fear, hostility) to any mention of homosexuality. Because a strong reaction in the client could come from a variety of sources, it does not always indicate an identity conflict. As before, the worker needs to be aware of the high-risk nature of this struggle and to proceed sensitively. Rather than using the label "lesbian" when doubts about sexual preference are raised, the worker can refer to the Kinsey scale and explain the idea of sexual attraction being on a continuum. Because most people are somewhere between 0 and 6, this information can serve to normalize a client's feelings and decrease her fear.

It is essential that the therapist provide accurate information about a lesbian lifestyle during this stage. This can be done by providing written material or connecting the client with various resources. Many women in the early stages of same-sex identification have all the stereotypes that the culture perpetuates. A woman may fear that she will have to make herself into a different person if she explores same-sex attractions. Thus, suggesting that she visit a women's

bookstore or coffeehouse could be helpful. She could observe the women there and see how she feels, and in that way start to deal with her own stereotypes and fears.

The worker needs to encourage discussion and expression of dissonance. The client's fears and ambivalence need to be verbalized and examined openly. The therapist must work hard—whatever his or her own biases—to provide information and support that validates the client's feelings as being worthwhile. If necessary, the worker could discuss with the client the cost of not dealing with dissonance. Rather than backing down in the face of the client's confusion and distress, the worker can reassure her that the feelings are normal and help her to resolve them and accept herself.

This time is a turning point. Depending on who she is and how she handles the dissonance, a client may choose to explore the feelings further or not. This is an individual choice that deserves respect at this stage in the process.

RELATIONSHIPS

What has been an internal and verbal process may next be translated into action. Because women are socialized to have and maintain relationships, sexual exploration and experimentation often take place within the context of a relationship. Schaeff says, "Women's sexuality seems more intimately connected to relationships than men's, and sex for a woman can be difficult or even unpleasant outside the context of a meaningful relationship."¹² However, lacking models and courtship experiences that felt right in adolescence, these first same-sex relationships tend to be stormy and unstable. There may be a period of many brief relationships that have a sense of being experimental. In trying to define, or redefine, what is important to her in relationships, a woman may try new behaviors. This may include multiple, nonmonogamous relationships; serial monogamy; and experimentation with roles. According to Lewis,

The lesbian's exploration of intimate experiences with other women is an emotionally turbulent process. It is, essentially, a second adolescence, complete with many

of the symptoms common to the mainstream heterosexual adolescent period.¹³

In trying to develop her own sense of what being a lesbian means, a woman may also experiment with styles of dressing. She may cut her hair short and wear jeans. According to Wolf, culturally defined masculine attire is "more strongly assumed by young women who are newly aware of their lesbianism and looking for a community. They may dress in a more extreme manner . . . in order to be recognizable as lesbians."¹⁴ Having been socialized to dressing attractively to "catch a man," some women rebel by paying little attention to their appearance or dressing in ways that are comfortable rather than socially approved.

First relationships are difficult and may be subjected to additional stress by a lack of social support. Without a larger community and access to other lesbians, two women, whose only real compatibility may be their sexual preference, could stay together for security and out of fear of never meeting another lesbian. These isolated relationships are often dependent and enmeshed. Even if a closeted lesbian knows where lesbians meet, she may fear being seen there and losing her job. Thus, the lack of community or social support can contribute to isolation of individuals and couples. In smaller communities, the bars may be the only gathering place. This can be a factor in substance abuse and low self-esteem.

As relationships are started there may be a further withdrawal from family. A woman may need to actively hide her involvement with a lover and become even more anxious and fearful about family consequences should she be discovered. According to Abbott and Love,

The feared break with parents epitomizes the total conflict with society. They know that lesbians who have told their families are sometimes unable to go home again, never permitted to see the children in the family or even to claim their possessions.¹⁵

On the other hand, having new relationships may serve as an impetus for coming out to one's family. A woman who has some support within a relationship may find it easier to

break the news to her family. In either case, dealing with family members becomes an important issue.

The search for community—a place to belong—is another important part of this process. As a woman begins to accept the label “lesbian,” she needs to have a support group who validate and accept that identity. Individuals cannot feel good about themselves if they are isolated from others who are like them. Today, with the rich cultures that have developed in conjunction with the feminist movement and gay liberation, there are many ways for a woman to find a community and meet other lesbians. In Minneapolis, for example, some examples of resources are a women's coffeehouse, a lesbian survival center, lesbian softball teams, a women's bookstore, a women's theater group, and a women's chorus. Thus, a woman who is exploring attractions to women can pursue her interests and use community resources to meet lesbians.

Separatists

Many women who are coming out define themselves as separatists for a period of time, or make an ongoing commitment to a separatist lifestyle. Separatists try to minimize or avoid all contact with men and often with nonlesbian women. For some women this means living, working, and socializing, as well as being intimate, only with lesbians. Others may carry it further and avoid male salespeople and try to support only female-owned or female-managed businesses. This lifestyle has many motivations. Living completely independent of men can give a woman a sense of total acceptance for the first time in her life. She may find new avenues of self-definition when she removes herself from the oppressiveness of the patriarchal culture. She may discover strengths and skills in herself that she formerly defined as male and that were thus unavailable to her. Within the context of a separatist lifestyle, she has the freedom to express her anger and rage at men because she is no longer dependent on them. There may also be considerable fear of men. A woman may feel that she does not know how to relate to men or what (if anything) she wants from them.

As a woman goes through a process of separatism, she will be free

to reevaluate her attitudes toward men and choose how and whether to relate to them. Thus, separatism can be an extremely healthy and active way for a woman to explore her own strengths, attitudes, and relationships. However, if she gets stuck there, she may be in a position of being perpetually reactive to men and never disentangle herself emotionally.

Nonseparatists

For a woman who does not like the idea of separatism, has male children, or wants to keep men in her life, there may be considerable pain, anger, and disillusionment with some community resources that are strongly separatist. This may further her isolation. She will need encouragement to keep exploring and looking for a place to fit.

While the client is finding a place to fit, the mourning process continues. The woman is usually past denying her lesbianism and is both angry and sad. For a woman who has related to men in the past there is anger at the loss of status in the culture that is called “heterosexual privilege.” The woman begins to realize the loss of such large and small benefits as feeling safe walking at night with a male companion, easy acceptance at work when talking of a boyfriend, and joint income-tax returns. There is anger and sadness at the loss of an easy sense of belonging with her family. Even if she has come out to her parents and they have accepted her, there will still be pain. For both parent and child, the intergenerational bond that comes when the younger generation has children and identifies with their parents may be lost. There is also sadness regarding the woman's own hopes and dreams about marriage, children, social acceptance, and the whole package of expectations from the culture. Feeling these losses and grieving them is an ongoing process that may take many years.

The social worker can continue to educate and support the client. Information about the process she is going through and support to experiment, explore, seek a community, and define her own needs are important aspects of this phase. The client may express contradictory feelings of excitement and relief about her sexual experiences with other women along with sadness and anger about what

she is losing. Often a woman will focus only on the excitement and try to deny the pain. It is important to make sure the losses are acknowledged, accepted, and resolved, or they may interfere later in the woman's intimate relationships. Also a worker needs to know that much anger and rage at men may be expressed during this phase. The practitioner must examine his or her own feelings about accepting the client's anger and dealing with it in a helpful manner. Experimentation with roles and relationships is part of a woman's search to define her own needs and wants.

A worker can help by educating the client about clear communication of needs, respecting differences, and learning to listen to oneself. Using the therapeutic relationship as a tool for teaching about honesty and expression of caring can be beneficial. At this time, a woman may have real difficulties with intimacy. She may not have had a real adolescence: While other girls were defining intimacy needs with boyfriends, she was pretending to fit in with peers or fantasizing about other girls. Thus, a developmental lag may be evident. A therapist can help a client clarify her own need for intimacy and how that balances with her need for independence. They can discuss the lack of positive role models, and the therapist can encourage the client to find and talk with lesbians who are at ease with their identity. Referral to an “exploring affections for women” or “coming out” group could be helpful. The therapist can talk about his or her own early love relationships, if appropriate, and how he or she learned to define needs. Abbott and Love write,

Readiness to become an acknowledged lesbian seems to involve a personal and emotional restructuring of values. . . . A good deal of energy goes into this process. The lesbian has to accurately perceive her motives and the consequences, and if she can get out from under the weight of old arguments and truly believe in the goodness of her love and the possibility of a rewarding personal life-style, she arrives at a new place.¹⁶

Family

Coming out to one's family is almost always experienced as a turn-

ing point. Women tend to do this in crisis or after having carefully weighed the pros and cons. The crisis may be a political one, such as a vote to prevent discrimination against gays, or it may be personal. The issue of coming out to one's family is frightening and difficult for many clients. However, many women work through their fears. As a woman becomes more accepting of her lesbian identity, she may grow discontent with the distance that concealing her identity necessitates and may decide to take the risk and tell her parents.

Reclaiming family relationships is an important step to a positive self-concept and an integrated identity. Clients should be encouraged to weigh the pros and cons, and to come out to family members when they are ready. If a woman has withdrawn to the extent that she has an extremely limited relationship with her family, a first step may be to get to know her parents and discuss other aspects of her life. As a bond is formed and strengthened, she will be better able to assess whether she can discuss her lesbianism with them.

A worker can be helpful by rehearsing the coming-out scenes with the client and role playing the parents' imagined responses. The worker can help the client focus on what to say and how to say it, line up support for the client before and after the event, and explore the client's worst fears and best possibilities. For most women, actually telling their parents is traumatic. However, with continued interaction and discussion, many families work things out. This is often a good time to encourage a client to invite family members in for some family sessions. It is important to help family members listen to each other's feelings and needs and learn to respect differences. Educating parents with books and pamphlets about lesbianism and referring them to a support group for families with a gay or lesbian member could also be helpful. Some women who feel certain of rejection choose not to disclose their sexual preference to their parents. This choice needs to be examined. If it is clear that the woman would lose more than she would gain, her decision must be respected. Wolf writes,

Many women are successfully integrated into the lesbian community, are in long-term relationships

with women they love, openly identify themselves as lesbians without constraint—and still find that they cannot tell their parents they are lesbians.¹⁷

STABLE LESBIAN IDENTITY

After a time of experimenting and exploring, a stable lesbian identity emerges. This is accompanied by a sense of settling down that is similar to finishing adolescence. Much of the earlier dissonance, fear, and anger is resolved and the woman is more self-accepting. She is also developing a community of friends with similar values who are accepted as her "chosen family" and are people she can go to for support, assistance, and companionship. She may spend her holidays and vacations with them. Often, at this time, an ongoing committed relationship is formed. In some larger cities, lesbian marriages in which two women exchange rings and promises are becoming more common. Many women buy homes together and have a committed relationship without undertaking any type of ceremony. Within this long-term relationship, both women experience a sense of settling into what feels comfortable. They define their roles according to what each of them likes to do, rather than trying to fit into a socially prescribed role. Potter and Darty state,

More women than men are apt to be involved in a quasi marriage marked by a relatively high degree of sexual fidelity. . . . It would appear that the most viable option for most lesbians may be that of a fulfilling and relatively monogamous "marital" relationship with another woman.¹⁸

Along with this committed relationship may come a stabilization of political ideas and identity. Some women who had been separatists begin including men in their lives. Much of the earlier reactivity and anger is resolved, and the woman feels she has found a niche for herself within her relationship, community, and, possibly, family.

This stabilization may take place gradually, over a period of years. A woman need not have a primary relationship to have stabilized her identity. Although lesbians may come in for or remain in treatment during

this stage, the focus will no longer be on coming out. Instead, relationships or work might be the focus. Once a woman has accepted her lesbianism and found a community, she often no longer needs therapy. Rather than focusing inward to resolve conflicts, she may begin focusing outward and become involved in the community, politics, or career advancement.

INTEGRATION

As time goes on, a woman integrates her lesbian identity into a positive self-concept, a process that is ongoing. A woman accepts and feels comfortable with her sexual identity. She chooses how much to discuss her lifestyle and with whom. She often becomes more public about her identity. She continues to find ways to be positive about herself as a woman and a lesbian. Rather than looming large as it did earlier, her lesbianism becomes one aspect of her life and demands less time and energy. There will still be pain and anger about discrimination, but, rather than blaming herself, she will know that the culture is oppressive.

Although this process as described in this article has seemed linear, often it is not. Most women go through parts of the process more than once and in various orders. A woman who had reached a sense of integration might be thrown back into a time of experimenting by the breakup of a long-term relationship. Or, a move from a supportive city environment to a small town could promote the woman's returning to earlier emotional stages.

Another variation is not uncommon. Occasionally, a woman will become involved in a sexual encounter or relationship with another woman without forethought—it seems to just happen. In this case, there will not have been a prior sense of difference and dissonance or a search for community. If a woman in this situation decides to work to integrate her same-sex feelings into her identity, the phases of development described in this article may follow her involvement with another woman. The model has been developed in the hope that practitioners will use it when it fits and that it will expand their understanding of a lesbian coming-out process as a complex, multifaceted journey to health and self-acceptance.

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Lou Ann Lewis, MSW, is Clinical Social Worker, Loring Family Clinic, Minneapolis, Minnesota. This article was presented at the Regional NASW Conference, "Empowering Women for Survival and Change: Social Work Practice in the 80's," Minneapolis, May 1982.

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16. *Ibid.*, p. 223.
17. Wolf, *Lesbian Community*, p. 31.
18. Potter and Darty, "Social Work and the Invisible Minority," p. 188.

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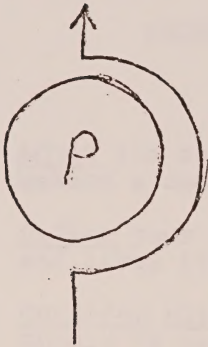
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PROBLEM SOLVING STYLES

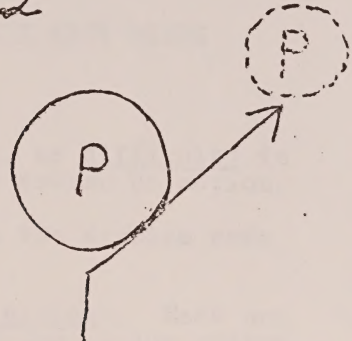
Most people approach problem solving in one of the four ways illustrated below:

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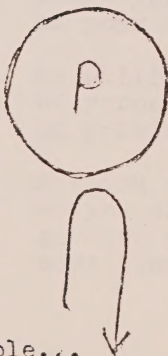
Some people...
Go around the
problem.

#2



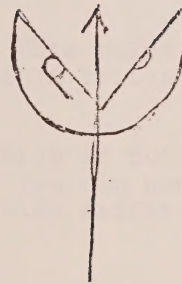
Some people...
Bypass the real
problem by creating
a substitute problem.

#3



Some people...
Turn around and run
away from the problem.

#4



Some people...
Work through the
problem and change
it.

*Note that In steps 1,2 and 3, the problem changes your behavior.
In step 4, your behavior changes the problem in some way.

Snellville Middle School
Joey Davis, Counselor
Clarissa Rice, Counselor

PROBLEM SOLVING MODEL IN SIX EASY STEPS

1. Admit you have a problem, conflict, or difficulty in making a decision or deciding on a course of action.
2. Define your problem. (Narrow down the problem area and label it.)
3. Consider all your alternatives or choices. Each one should be weighed against your personal value system as a process of elimination takes place. Choices can be grouped broadly under the following headings:
 - a. Confront
 - b. confront and negotiate
 - c. "grin and bear it"
 - d. escape
 - e. no choice (Remember - not choosing is a choice)
4. Act on your choice or decision. Take a risk! At this point you must consider all the possible consequences of your decision.
5. Be willing to take the consequences. This helps us to be responsible for our behavior and learn better ways of solving problems in the future.
6. Rethink and redo. If solution to problem is not achieved, or you did not like the consequences, you can usually go back to steps 3 and 4 again and decide differently next time.

Sophie Freud Loewenstein

Understanding Lesbian Women

Lesbian women are as diverse in childhood histories, personality characteristics, and relationship styles as heterosexual women. Social workers can offer lesbians particular assistance in issues related to self-esteem and can help mediate their acceptance by courts in custody cases, by their parents, and by society in general.

Sophie Freud Loewenstein is a professor, Simmons College School of Social Work, Boston, Massachusetts.

HOMOSEXUAL WOMEN HAVE COME out of the closet in the past ten years. The current sexual revolution has made it less imperative for the new generation of young women to hide a lesbian orientation. As a consequence, lesbian women are becoming a somewhat more integrated part of the general population, appearing as clients in social agencies and with private therapists, rather than using separate lesbian resources. Indeed, to paraphrase their motto: Lesbian women are everywhere. "Everywhere" includes social work schools, where lesbians form an invisible but increasing minority among students and faculty members.

Social workers have a special mandate to be sensitive to the needs of minority members within the general community and within their own ranks. This article will review current thinking about lesbian women to help social work professionals deal with lesbian women as clients, as students, and as colleagues. The article is based on the author's information from acquaintance and friendship with many lesbian women, on some of the current literature, and on her ongoing study of passions in women's lives.

Definitions

Homosexuality can refer to men or women, because the prefix "homo" refers to the

Greek word "same" rather than the Latin word "man." Although it is a correct and somewhat neutral word, it has acquired a connotation of stiltedness and distance with usage by an unsympathetic majority, as happened to the word Negro. Stephen Morin, a member of the Task Force of Gay Psychologists, suggests that "homosexual," as a self-reference, connotes a negative identity, while "gay" conveys pride and self-acceptance.¹ Although he spoke for gay men, gay women also do not refer to themselves as homosexual. Gay women are comfortable with the label "lesbian," which is coined from the Greek Island of Lesbos, home of the famous Greek lesbian poet, Sappho. The most common derogatory word for lesbians is "dyke," and like "nigger," it has become a playful in-word of the lesbian subculture.

An outdated definition of lesbians emphasizes their sexual activity. The newer, feminist view defines lesbianism "as pertaining to women whose primary sexual and emotional attractions are fulfilled... by women."² The sexual aspect of lesbian relationships is important, but it is not always the primary element in a lesbian's self-definition. Some women, so-called "head-

1. Stephen Morin, "On Fostering Positive Identity in Gay Men: The Implications of Gender Identity Research and Treatment." Speech delivered at the Annual Meeting of the American Orthopsychiatric Association, San Francisco, California, 31 March 1978.

2. Dolores Klaich, *Woman Plus Woman* (New York: Simon and Schuster, 1974), p. 10.

lesbians," define themselves as lesbians but choose celibacy. Generally, lesbians are reported to care about the romantic, emotional aspects of their relationships at least as much as "straight" women do.³ In this respect, their socialization did not fail them!

For many women, a public self-definition as "lesbian" or "woman-identified" is also a political statement. The lesbian-feminist theorist Charlotte Bunch explains that "a woman-identified woman" is a feminist who adopts a lesbian-feminist ideology and enacts that understanding in her life, whether she is sexually a lesbian or not. Neither all lesbians nor all feminists think of themselves as "woman-identified."⁴ The essence of a woman-identified ideology is to take a critical stance toward heterosexuality, which is seen as embedded in the institutions of society and as an essential part of male supremacy.⁵

Love-Object Choice and Gender Identity

Careful studies of transsexualism and homosexuality have definitely clarified the difference between love-object choice and gender identity.⁶ These two characteristics have been so persistently confused that homosexual men with *masculine* gender identification may experience years of bewilderment and uncertainty.⁷ There is general agreement that *core gender identity* is established in the second year of life, although there is much controversy regarding the age at which love-object choice is settled, from early life, to the oedipal period, to the juvenile period, to adolescence,⁸ or whether it is in-

deed ever permanently fixed or even a discreet characteristic. This last point will be further developed below.

Lesbian women have been thought of as masculine. Marcel Saghir in his highly respected study of fifty-six homosexual women demonstrates such stereotyping. The study shows that during preadolescence and adolescence one-third of the sample assumed traditional feminine behavior and two-thirds were tomboys. "They express disinterest in feminine accessories and fashion, prefer 'sporty' and tailored clothes and shun make-up and hair-do. . . . They behave more competitively and are oriented towards career and accomplishment with little interest in raising children and domestic pursuit."⁹ The absurdity of some of these superficial "feminine" attributes is readily seen as outdated sex-role stereotyping. The bitter legal battles that lesbian mothers have fought for custody of their children belies the statement that lesbians lack maternal interest. Although various degrees of gender inversion (transsexuality) may indeed coexist with a homosexual love-object orientation, the two are separate characteristics that need to be carefully differentiated by mental health professionals. In fact, it is the feminine style that is valued in the lesbian subculture, that stresses mutual supportiveness, open communication, and emotional expressiveness as behavioral ideals.

The Question of Normalcy and the Search for Causes

Research on homosexuality usually focuses on a search for causes and on the degree of normality or abnormality of homosexual persons. Although the initial focus of interest was limited to male homosexuality, eventually women were studied and the research took the same route.¹⁰ Research results seem

3. Ralph H. Gundlach and Bernard F. Riess, "Self and Sexual Identity in the Female: A Study of Female Homosexuals," in *New Directions in Mental Health*, ed. Bernard F. Riess (New York: Grune and Stratton, 1968).

4. Charlotte Bunch, "Lesbian-Feminist Theory," in *Our Right to Love*, ed. Ginny Vida (Englewood Cliffs, N.J.: Prentice-Hall, 1978), p. 181.

5. *Ibid.*, p. 180.

6. See Robert Stoller, *Sex and Gender* (New York: Science House, 1968).

7. Howard Brown, *Familiar Faces, Hidden Lives* (New York: Harcourt Brace Jovanovich, 1976).

8. See Robert J. Stoller, "Primary Femininity," *Journal of the American Psychoanalytic Association* 24, no. 5 (1976): 59-78; Marcel Saghir and Eli Robins, *Male and Female Homosexuality* (Baltimore: Williams and

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generally heavily influenced by the particular investigator's initial bias. The behavioral science field is sharply divided into pathology and antipathology views, apparently based on philosophical considerations rather than on research results. In the sense of normal as "statistical average," homosexual persons are indeed abnormal, deviant from the majority. In the sense of normal as "mentally healthy," much depends on whether heterosexuality is included in the definition of mental health. The only clear-cut negative result of a whole array of psychological tests in which "blind judges" tried to differentiate self-defined lesbian from nonlesbian women, was a higher incidence of alcoholism among lesbian women.¹¹ It has been suggested that the gay bar as a common homosexual meeting place, along with the pressures of the lesbian life-style, may contribute to lesbian alcoholism. Counselors of gay women should be aware of the existence of lesbian Alcoholics Anonymous groups in most major cities. On some tests lesbians had higher scores on such socially desirable traits as inner-directedness, assertiveness, and autonomy.¹²

Childhood History

Attempts to trace typical childhood histories for lesbian women have also largely failed in that they have produced many different, contradictory hypotheses. One investigator sees the lesbian parental family dynamics as consisting of a possessive, binding father coupled with a rejecting mother, another psychiatrist claims that the usual family constellation is a hostile, exploitative, detached or absent father coupled with a

man-hating and/or distant mother, and a third view is that of a distant, uninvolved father and a close, binding mother.¹³ In view of the fact that every child's first love object is the mother, it is possible that some girls do not make the transition from mother to father, especially in the presence of a binding mother. Wolfe defends these hypotheses and sees the possibility that a cold, rejecting, or unpredictable mother creates a yearning for such elusive motherly-womanly love.

The psychoanalytic school has suggested other possible developmental experiences: narcissistic fixation or regression to a love object similar to oneself; intense penis envy inducing a masculinity complex; excessive incestuous attachment to father, leading to avoidance of all men as incestuous objects; and fear of and aversion to male sex organs.¹⁴ Some of these factors may apply to some lesbian women, but no one theory applies to all lesbian women. The results of these studies have led many researchers to agree that "homosexuality is simply not a clinical entity."¹⁵ Lesbian women are extremely diverse in personality, family constellation, and developmental experiences, and categorizing them as a group becomes as meaningless as categorizing all heterosexual women. Stereotypes of lesbians as man-haters, as obsessed with sex, as immature, as masculine or aggressive apply to some lesbians (as well as to some heterosexual women), and they are false for others. Homosexuality has been alternately or simultaneously labeled a crime, a sin, a sickness; three labels that have oppressive, guilt, and shame-producing consequences. It is fortunate that professionals have become aware of the cruel effects of stigmatization in the name of mental health.¹⁶

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15. Riess, "New Viewpoints on the Female Homosexual," p. 195; and Alan P. Bell and Martin S. Weinberg, *Homosexualities* (New York: Simon and Schuster, 1978).

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The Effects of Discrimination: Passing and Telling

Lesbians have different personalities, but they all have one common experience that draws them together: discrimination. The fact that lesbian women could barely be distinguished from their controls on psychological tests speaks to their courage, strength, and resilience, because the daily management of a stigmatized identity could be expected to have a corrosive and debilitating effect. Erving Goffman's brilliant analysis of the effects of bearing a stigma gives an excellent framework for understanding the experience of all stigmatized groups in our culture.¹⁷ Goffman distinguishes between people who must manage "discredited" (visible stigmas) or "discreditable" (invisible stigmas) identities. Lesbian women have discreditable identities (invisible stigmas) and are, therefore, faced with difficult choices about "passing" and "telling."¹⁸ Passing, "staying in the closet," protects lesbians against job or housing discrimination, social contempt, and general harassment—all particularly distressing for women who stand alone. Passing, however, exacts a high price. Passing along some important dimension of self—we all pass to some extent—involves the burden of a double identity, a public and a private one. It may lead to a sense of alienation and to inauthentic or deceptive interactions. There is also the danger of being "found out" and the danger of being inadvertently exposed to insults against one's secret self. Passing may bring security at the price of social and emotional isolation.

Telling is referred to in the homosexual subculture as "coming out of the closet" or "coming out." It is seldom done in a single, dramatic step, but is a gradual, sometimes lifelong, process involving innumerable decisions regarding whom to "tell," when, and how much to do so. J. Lee Lehman distinguishes five stages of coming out:¹⁹

1. "Coming out to oneself"; gaining

awareness, understanding, and acceptance of one's own feelings. This is often emotionally the most unsettling step, entailing a drastic revision of one's identity and of one's basic assumptions, values, hopes, and expectations.

2. Coming out sexually; initiating or responding to sexual overtures.
3. Coming out to friends and/or family.
4. Coming out publicly.
5. Coming out politically.

The decisions regarding telling need to be carefully and repeatedly evaluated. Many women take only some of the above five steps. Janet Chafetz, in a study of fifty-one lesbian women in Houston, Texas, found that most women revealed themselves only to a limited degree, because of fear of economic reprisals and social and familial rejection.²⁰ Many lesbians do not choose to take active part in political action, but every woman's coming out has inevitable indirect political repercussions, setting up waves in her social and kinship network and, perhaps, slowly leading to increasingly accepting attitudes. Because of these political implications, lesbians, especially those of status and achievement, may experience considerable peer pressure to reveal themselves as lesbians.

Self-Esteem

Because stigmatized persons in our society have been raised with the majority cultural values, they are vulnerable to self-hatred, regardless of whether the stigma is based on race, ethnicity, physical characteristics, or "shameful" secrets. Goffman mentions various possible "moral careers" for stigmatized persons, depending on how early in life they found themselves to be shamefully different.²¹ Longtime lesbian women who had to live in hiding for years seem to harbor more self-hatred than lesbians of the newer generation who have reaped the benefits of new and enlightened sexual attitudes.

Most people have an intense need for respect and affirmation and find it hard to live on the fringes of society. The first step in the liberation of oppressed groups is to foster a sense of pride and self-acceptance. Coming

17. Erving Goffman, *Stigma* (Englewood Cliffs, N.J.: Prentice-Hall, 1963).

18. Ibid., pp. 73-104.

19. J. Lee Lehman, "What It Means to Love Another Woman," in *Our Right to Love*, ed. Vida, p. 25.

20. Janet Chafetz et al., "A Study of Homosexual Women," *Social Work* 19 (November 1974): 714-23.

21. Goffman, *Stigma*, pp. 32-40.

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out may be an important act of self-
acceptance for a woman, helping to overcome
shame and low self-esteem. Below is what one
thirty-year-old social worker wrote on her
questionnaire: "I will say, being gay, that I
have had more than the usual obstacles to
overcome in intimate relationships. It is also
more difficult to have a healthy self-esteem
when society scorns you. This was par-
ticularly true when I was younger. I think I
have come to terms with my homosexuality
and accept myself much more now. I feel
good about my capacity to love and be loved
in return—does it really matter if it is a man
or a woman?"

There is yet another dimension to passing
and coming out. Adrienne Rich describes the
terrible price of artistic inhibition that
professional lesbian women may pay for
leading "a censored life," and, conversely,
their flow of creativity when they acknowl-
edge their lesbian identity.²²

Once lesbians have come out to some ex-
tent, they can turn for support toward each
other and toward the lesbian community,
which may offer the self-affirmation and the
protection against isolation sometimes un-
available from family, church, or work. It is
also here that rules of conduct and survival
techniques for lesbians are learned.

The Joys and Difficulties of Lesbian Relationships

There is sharp controversy in the lesbian
literature on the advantages and disadvan-
tages of sexually exclusive, monogamous re-
lationships and on the general possibility of
sexually and emotionally "open" relation-
ships.²³ Lesbians, unlike male homosexuals,
do not indulge in compulsive "cruising" and
nobody has accused lesbians of promiscu-
ity.²⁴ Many lesbians express a need for a
traditional lifestyle for their socially deviant
relationship. Saghir reports that most women

in his sample started each relationship with
the hope of a lifetime union, but that
relationships lasted an average of three years,
with a range from one to seventeen years.²⁵
An autobiographical novel by Kate Millett
deals in depth with such issues as jealousy,
possessiveness, and fear of abandonment in a
nonexclusive lesbian relationship.²⁶

Friendship

Lesbians devote much energy to cultivating
friendships, sometimes perhaps as a sub-
stitute for the kinship networks in which
straight women are often involved. The
women in Chafetz's study had both straight
and gay men and women friends, but when
asked to whom they would turn in a life-
crisis—a true sign of friendship—they men-
tioned their gay women friends or lovers, thus
indicating their primary emotional bonds
with gay women.²⁷ Although some lesbian
women enjoy and prize their friendships with
gay men, other more separatist women frown
upon such friendships. Friendships with
women may occasionally include sexual con-
tacts and then revert to "pure friendships."
Lesbian women often try to convert former
sexual love relationships to friendships, no
unlike some heterosexual women.

Passionate Emotions

Lesbians talk about their intimate rela-
tionships with a great deal of passion. The
first sexual love relationship after coming out
sexually is described in extremely glowing
terms, as illustrated below:

- A forty-seven-year-old married woman
biologist wrote that her first lesbian love
"... has awakened me from a long sleep."
- A thirty-eight-year-old woman who had
an early young adult heterosexual passionate
love affair, followed by a devitalized marriage
that was disrupted by a homosexual love af-
fair, wrote: "This last passion was so
overwhelming I hesitate to call all previous
ones passion. It made me understand who

22. Adrienne Rich, "Conditions for Work: The Common World of Women," in *Working It Out*, ed. Sara Ruddick and Pamela Daniels (New York: Pantheon Books, 1977), pp. xx-xxi.

23. See Jeri Dilno, "Monogamy and Alternate Life-Styles," in *Our Right to Love*, ed. Vida, pp. 56-63.

24. Saghir and Robins, *Male and Female Sexuality*, p. 229; and Klemesrud, "Disciples of Sappho."

25. Saghir and Robins, *Male and Female Homosexuality*, p. 236.

26. Kate Millett, *Sita* (New York: Farrar, Straus and Giroux, 1976).

27. Chafetz, "A Study of Homosexual Women," p. 719-20.

1. "A Study of Homosexual
9 (November 1974): 714-23.

32-40.

others have felt along this line.... I previously thought it did not exist."

• A twenty-two-year-old woman wrote about her first and only passion: "It was particularly stunning to me because it made me admit or should I say accept my homosexuality.... Through this relationship I've gained individuality, assertiveness, increased my self-esteem, and developed an open mind of doing things that always seemed foreign to me. This initial feeling was one of such bliss and contentment, excitement... that I've never witnessed before."

Lesbian writers emphasize the advantages in the lesbian relationship. Ginny Vida writes about the greater opportunity for equality, independence, and pursuit of career goals. She sees the possibility of deeper levels of affection, support, mutuality, and understanding than is ever possible in heterosexual relationships.²⁸

However, neither heterosexual nor homosexual passions can be maintained at such blissful peaks and avoid the harsh light of everyday reality that always interferes with continuing idealization of the lover. Passions may change to indifference, hostility, or, under favorable circumstances, creative and companionable friendships. The most remarkable aspect of lesbian love relationships is that they are stunningly similar to heterosexual relationships, with similar peaks of ecstatic love and abysses of hate. Each of the thirty-three women in the author's passion study who had sexual love experiences with other women report about the same number of passions as their heterosexual counterparts; they describe their love relationships in similar terms, and they seem to have the same joys and pains and disappointments and betrayal experiences. The author would like to say that love between women has a smoother course than heterosexual love, but this would belie her research findings and observations.

Moreover, relationships between women have additional burdens. When difficulties arise, the strong motivation of preserving common parenthood or the reluctance to disrupt formal legal bonds are lacking. Our

society gives no kinship recognition to homosexual bonds. As a result, there are additional stresses during times of sickness and hospitalization or the death of one partner, with no legal rights regarding inheritance or child guardianship. One wonders how many heterosexual unions would survive without the benefit of social sanctions and financial or parenthood considerations. Women are faced with the difficult task of building new relationships that are not necessarily bound by available traditional heterosexual models.

Monogamy

Some lesbian women live in a monogamous relationship quite similar to traditional marriages. Such relationships may even include children of a former marriage of one or both women involved. Imitation of male/female stereotypical roles, resulting in the butch/femme relationship, is still practiced among working-class women and old-style lesbians. The new, middle-class, politically feminist lesbians are critical of such relationships, and these political differences create tensions and sometimes bitterness in the lesbian community. The "new generation" lesbian couples strive toward an ideal of equality, but unequal role assumptions and power differentials are not easily eliminated. Lesbian long-term "marriages" are not necessarily always more totally fulfilling than heterosexual marriages; compromises are made in both the gay and the straight world. A forty-eight-year-old gay psychologist writes: "I am in a comfortable, affectionate, unstimulating relationship with good sex and mutual political respect. I wish it were more exciting intellectually.... I am willing to stay in it."

Social workers who have done marital counseling will find the difficulties of lesbian couples very familiar. Relationships may become overloaded with excessive hope, expectations, and especially dependency needs. One self-defined lesbian in the author's study wrote: "I felt confined by too much togetherness and no room to reach out to her because she loved me too much, was too dependent on me for her happiness." Millet, in *Sita*, frequently refers to the issues of autonomy, of finding a balance between personal space and intimacy, and of in-

28. Ginny Vida, "Introduction," in *Our Right to Love*, ed. Vida, p. 16.

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terdependence versus holding on to a firm separate identity within a close relationship. Chodorow points out that "mothers and women tend to identify more with daughters and to help them to differentiate less, and that processes of separation and individuation are made more difficult for girls."²⁹ We thus find that many women have a tendency to merge identities in intimate relationships and it is not surprising that excessive fusion should emerge as a primary problem in an all-women relationship.

In *Sita*, Millet describes the agony of the breakup of a lesbian love relationship. Kellogg argues that lesbian women are particularly vulnerable to extreme pain and depression at such times.³⁰ There is the initial incredible joy of finally having found true communion, described earlier, so that the crash comes down from great heights. The relationship may have been an affirmation of lesbian identity, making up for the lack of confirmation from the larger society. The lover may have been a protection against loneliness and discrimination in a homophobic society. Excessive emotional dependency and fusion may leave the woman without anchorage or firm identity. Perhaps, above all, the narcissistic injuries inflicted by loss and rejection are particularly painful to women whose stigmatized identity may harbor self-doubts. It is a time when lesbian women are apt to seek help with their despair.

The similarities of difficulties in homosexual and heterosexual relationships lead to the reflection that *all* intimate relationships have built-in problems about ambivalence and proper emotional distance, that will transcend cross-gender hostilities and misunderstandings.

Sexuality

Lifelong love between women that has never been translated into the sexual sphere has been known, but the majority of open self-defined lesbians tend to be sexually

passionate women. Except for coitus, the sexual activities between two women are similar to heterosexual activities.³¹ Lesbian women hug, kiss, and caress each other and practice mutual masturbation, either simultaneously or taking turns, using fingers, tongue, or a combination of both. Sometimes sexual play is very prolonged, at other times it is rapidly focused on obtaining orgasm. Lesbians claim that women are more skillful lovers because they have more intimate knowledge of the lover's body. The use of dildoes is quite infrequent. Women are more likely to have orgasms masturbating than during coitus, making lesbian sex a more likely road to orgasm.³² As mentioned earlier, lesbians, like the majority of heterosexual women, do not enjoy sexual relations without love and tenderness. Lesbian women feel that their relationships with women are more complete emotionally, physically, and spiritually than they could ever be with men. However, non-exclusive but self-defined lesbians are sometimes attracted to men and may engage in heterosexual affairs. This does not usually mean that they are changing their lesbian identity.

Lesbianism continues to be associated primarily with female sexuality. It thus comes as a surprise to learn that lesbian women and lesbian couples have their share of sexual problems quite similar to the general population.³³ Lesbians may have primary or, more frequently, secondary orgasmic dysfunction, when relationship problems are expressed in the sexual realm. Some lesbians continue to have conflicts with their homosexual inclinations, expressed in fear of being touched, in sexual inhibitions, or in highly ritualized lovemaking patterns. There may also be a dislike of genital/oral contact, a dislike that may become a problem in many lesbian relationships in which cunnilingus is a frequent practice. Toder suggests that the causes for such problems are quite similar to those of heterosexual dysfunctions. There

29. Nancy Chodorow, "Family Structure and Feminine Personality," in *Woman, Culture and Society*, ed. Michelle Z. Rosaldo and Louise Lamphere (Stanford, Calif.: Stanford University Press, 1974), p. 48.

30. Polly Kellogg, "Breaking Up," in *Our Right to Love*, ed. Vida, p. 55.

31. Klaich, *Woman Plus Woman*, pp. 38-54.

32. Sophie Loewenstein, "An Overview of Some Aspects of Female Sexuality," *Social Casework* 59 (February 1978): 113.

33. Nancy Toder, "Sexual Problems of Lesbians," in *Our Right to Love*, ed. Vida, pp. 105-113.

may be relationship difficulties, deeply ingrained intrapsychic conflicts, fear of losing control, fatigue, depression, communication failure, frightening sexual experiences, or simply lack of information, in addition to guilt about homosexuality. Proposed treatments vary with causes and are largely similar to those used for heterosexual dysfunctions.

Lesbians as Family Members

Lesbian Daughters

Telling parents is a particularly anxiety-provoking task for most lesbian women. Single women may wish to continue to look to their parents as their closest kin with whom they can exchange friendship and support. The prospect of being condemned and rejected by her parents is, thus, particularly painful for a young, single woman who already lacks public support and approbation. A hostile break between parents and children is always tragic for both generations, because aging parents receive affirmation and emotional strength from the love and respect of their adult children. Several situations are known to the author in which parental rejection has extended to the grandchildren, involving a tragic loss for the grandparents. Social workers could become mediators in such situations. As a first step, a woman should be encouraged to inform her parents of her lesbianism at a time when she feels strong and relatively at peace with her new identity. Hinting about things is usually not sufficient, because parents are adept at denying painful facts. The woman must be prepared for an initially pained and outraged reaction. After the first shock has worn off, many parents manage to work through or let go of their guilt, self-blame, shame, anger, and disappointment and accept their daughter as she is, rather than holding on to the fantasy child that they had hoped for.

Parents might ask for or be offered help in this process of letting go and acceptance, which is after all a lifelong parental task and the essence of "good enough" parenting.³⁴

Parents might also need help with the various stages of accepting, passing, and telling, all of which they have to face in relative isolation. Parents might be encouraged to join self-help groups organized in many cities for the purpose of mutual support and problem solving. Parents reach different stages of acceptance. In some families, the mother is delegated to become the link between the erring daughter and the unforgiving father. Other parents will continue pleasant relations with their daughter, but carefully avoid the taboo subject of homosexuality and not welcome any of the daughter's gay friends or lovers. Finally, however, there are parents who adopt the role of the "wise," Goffman's term for the stigmatized intimate others who, after having passed through a "heart-changing personal experience," embrace their children's cause and fight against discrimination from a stand of "respectability."³⁵

Lesbian Mothers

Because many women become lesbians after years of heterosexual marriage, many lesbians are mothers. They are mothers who insist on their right to raise their own children while carrying the double burden of being single and lesbian. A 1976 Maine court case, in which the author was involved as a social science expert witness, involved kidnapping, taking flight from state to state, and repeated, contradictory court orders. The price of such harassment is very high. In court hearings, the woman's lifestyle and child-rearing methods are humiliatingly scrutinized and held up to ideals that most parents could not meet.³⁶ The two explicit or implicit reasons for removing a child from a lesbian mother is that the child might adopt a similar deviant sexual orientation or that the child would be growing up in an emotionally unhealthy atmosphere. A note of enlightenment was rung by one state's recent superior court decision, which ruled that a mother's sexual preference was irrelevant to her fitness as a mother. The court even stated that the children might gain tolerance and courage

34. Albert Solnit and Mary Stark, "Mourning and the Birth of a Defective Child," in *Psychoanalytic Study of the Child*, vol. 16 (New York: International Universities Press, 1961).

35. Goffman, *Stigma*, p. 28.

36. Benna Armanno, "The Lesbian Mother: Her Right to Child Custody," *Golden Gate Law Review* 4 (Fall 1973): 1-18.

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from their exposure to prejudice and bigotry.³⁷

It has frequently been pointed out that today's homosexuals grew up in "straight" families. The one recent research report available suggests that growing up in a homosexual household does not contribute to a child's homosexuality.³⁸ There is, of course, the sad likelihood that these children may be socially ostracized, pointing to the urgent need for public enlightenment. Some mothers stay in the closet to protect their maternal rights, while others join forces and form a common household to help each other in the difficult task of single mothering.³⁹ Most lesbian mothers make special efforts to assure their sons male companionship if their fathers are not available.

Lesbian mothers may be kind or harsh, wise or foolish, and sometimes they might be unsuited to take care of a child. Such judgments must not be made on the basis of a woman's sexual orientation, and mental health professionals should take an advocacy position in this matter.

Minority Lesbians

Particularly sharp conflicts may be experienced by lesbian women from minority groups. Such women may carry a double burden of stigma, in addition to acute loyalty conflicts. Different minority women express this conflict poignantly in *Our Right to Love*:

"When my white sisters advocate that we try to create our own family structure within the lesbian-feminist community and spend holidays together or ignore the parents that won't accept our lesbianism, they have difficulty understanding the internal struggle I have. I may be looked upon as unliberated by lesbian feminists, and would like not to feel as totally obligated to my family as I do, but I ultimately don't want to lose that sense of family identity as much as my white sisters do. . . . Yet I cannot ignore my own oppression as Puerto

Rican. I feel caught between two irreconcilable worlds. . . . As a lesbian who has actively participated in both (cultures) I am pained by the contradiction I experience because my feelings are warm and loving for the good things I see in each one."⁴⁰

Some minority women feel that the gap can be bridged, but their first allegiance belongs to their own ethnic/cultural group: "My identity is primarily as a Native American; my people's struggles are first for me."⁴¹

Conclusion

Many people question whether therapists can help people whose lifestyle and perspectives are radically different. There are doubts regarding cross-gender therapy, cross-racial therapy, and even cross-ethnic or religious therapy. The encounter of two very different human beings can lead to creative growth in both, if each is open to exploration and to seeking understanding. Sometimes, the very fact that the therapist is different and does not exude a "know it all" attitude forces the client to explain and explore her own situation in new depths.

Lesbian women need to be "accepted and affirmed. . . rather than being tolerated or feared or treated as invisible."⁴² This must be the basis on which therapeutic work can be built.

Therapists, men or women, who have a deep conviction that the heterosexual, monogamous lifestyle is superior to all others might not be of any help to lesbians. To work with lesbians, therapists must also have freed themselves of the conviction that a homosexual orientation is pathological, regressive, or immature. They must feel that the gay lifestyle is a valid, potentially gratifying option, rather than an unfortunate phase. Therapists must be particularly attuned to the crisis of coming out and treat it as any other

37. Lacy McCrary, "On Tolerance and 'Fortitude'," *The Philadelphia Inquirer*, 24 July 1979, p. 3.

38. Richard Green, "Sexual Identity of 37 Children Raised by Homosexual or Transsexual Parents," *American Journal of Psychiatry* 135, no. 6 (June 1978): 692-97.

39. "The Lesbian as Mother," *Newsweek*, 24 September 1973, p. 61.

40. Zulma Rivera, quoted in Audrey Lorde, "I've Been Standing on the Street Corner a Hell of a Long Time," in *Our Right to Love*, ed. Vida, p. 227.

41. Barbara Cameron, quoted in Audrey Lorde, "I've Been Standing on the Street Corner a Hell of a Long Time," in *Our Right to Love*, ed. Vida, p. 229.

42. Dorothy I. Riddle, "Finding Supportive Therapy," in *Our Right to Love*, ed. Vida, p. 89.

major psychosocial transition.⁴³ They must be sensitive to the cumulative stresses and the ever-present possibility of shame and self-hatred involved in being a stigmatized person in our society. It is just as important however, once this basic awareness has been secured, that lesbian clients be viewed as any other human being with a particular character

structure who encounters problems in coping with life.

Social casework, contrary to some opinion, is a value-laden enterprise. Social workers have the awesome power to confer approval or disapproval onto others. They bring their values to their work and transmit them to clients, knowingly and unknowingly. This article has been written from a value-laden perspective because the author believes that social workers must take sides on the thorny value issues of our time.

43. Colin M. Parkes, "Psycho-social Transitions: A Field for Study," *Social Science and Medicine* 5 (1971): 101-15.

"I'd Rather Be Dead Than Gay": Counseling Gay Men Who Are Coming Out

Many men who recognize they are homosexual have a difficult time feeling positive about their homosexuality and accepting it as part of themselves. In this article I focus on the initial phase of counseling men who want help in feeling positive about and accepting their homosexuality. My assumption about homosexuality is that it is neither a disease nor something simply to be tolerated. It is as valuable as heterosexuality.

This article is based on my experience counseling men who are gay or homosexual, my experience as a gestalt therapist, and my experience as a gay man. Within the gay subculture

there is a distinction between gay and homosexual. The word *homosexual* has a negative connotation because it has been used as a diagnostic label by many clinicians, pertains only to sexual orientation, and is usually accompanied by a negative self-image. The word *gay* has come to connote an attitude of positive self-acceptance, which includes emotions, affection, life-style, and political perspective as well as sexual orientation. (For an in-depth perspective of homosexual identity formation see Cass, 1979; Troiden & Goode, 1980.)

Although the focus here is on the initial phase of coming out¹ and feeling good about being gay, most of the concepts are applicable for counselors working to develop a positive gay identity at any point in a gay man's life. The process of coming out as a gay person and "developing a positive gay identity" (Berzon, 1979) are lifelong endeavors. Whether one is 16 or 60, living in Los Angeles or rural Pennsylvania, the process of accepting one's homosexuality and developing a positive gay identity are somewhat universal. A negative gay identity or nonacceptance of one's homosexual feelings is not restricted to people who have not come out but can be firmly established in a gay person who has been out for many years.

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A negative gay identity is someone who is out of the closet is often the basis for issues such as guilt, shame, problems with intimacy, sexual dysfunction, and substance abuse. These issues are important when counseling gay men but will not be discussed in this paper.

DEVELOPING A POSITIVE GAY IDENTITY

From a gestalt theoretical perspective the self is formed through the ongoing process of identifying and not identifying with the people, ideas, images, and concepts in one's environment (Perls, 1973). When a man grows up realizing he is homosexual but never sees any other homosexuals with whom to identify, he usually develops a negative gay identity.

Everyone feels different growing up, but the experience of the gay person is unique. As Black or Jewish children grow up, they see and interact with other Black and Jewish people, and their families are almost always from the same minority group. It is not so with the gay man who grows up in an environment that appears to be totally heterosexual. Almost every gay man I have ever known, whether friend, client, or colleague, has had the experience of feeling as if he was "the only one," often for many years (Clark, 1977, 1979).

If models or images of gay men were available they were negative: the child molester, the self-hating, effeminate hairdresser, or the friendless, isolated older gay man whom everyone pitied or tolerated until he ended it all. Those kinds of images are enough to make anyone shudder and decide that anything is better than being gay, which is exactly what many men feel in the early stages of developing a negative gay identity.

A negative gay identity can range from mild ambivalence and confusion about one's sexual orientation to intense self-hatred, fear, and abhorrence of being gay, as in the case of the Orthodox Jewish doctoral student in clinical psychology who said, "I'd rather be dead than gay."

The originator of that statement is someone who has been socialized by a culture that is antigay and homophobic, *homophobia* being the irrational fear of homosexuality and homosexuals (Weinberg, 1973). The speaker is also someone who is a victim of the cultural conspiracy of silence and shame that has been extremely effective in keeping gay men disliking of themselves and hidden. It is only within the past 10 years that significant numbers of lesbians and gay men have begun to end the conspiracy of silence by being publicly gay, providing positive models for other gay men and lesbians.

INITIAL AWARENESS WORK

I have found gestalt therapy and some specific gestalt concepts to be effective in working with male clients having difficulty accepting their homosexuality. Gestalt therapy is a process of looking at one's self to become aware of how one is functioning in the world. Emphasis is on becoming aware of that which is occurring moment by moment without judgment or interpretation from the client or therapist. "Awareness" or the ability to become aware of what one is sensing, feeling, thinking, or believing moment by moment is one of the main tools as well as goals of gestalt therapy. This existential, phenomenological examination of the client's experience during the therapy hour reveals how the client exists, thinks, feels, and behaves in his day-to-day life (Yontef, 1976). Recognizing and owning one's immediate experience leads to an increased level of awareness that in turn leads to more self-acceptance, the first step towards change. In addition to awareness, contact and support are basic gestalt concepts that are important.

Awareness work in gestalt therapy occurs in many stages and at many levels. An important place to begin with the client who is coming out is reevaluating the values he has introjected or swallowed whole. Four areas in which he will frequently have introjected beliefs that affect his coming out are: basic

values about homosexuality, gay male stereotypes, the male role, and sexuality.

HOMOPHOBIC INTROJECTIONS

Typically the homophobic values and beliefs he has introjected dictate that homosexuality is illegal, immoral, sick, sinful, disgusting, unacceptable, and a mental illness. His introjecting has led him to decrease his aliveness and excitement by numbing the feelings of warmth and sexual excitement he experiences when he begins to care for another man. He has disowned his emotions and feelings because they bring about guilt and shame. He has disowned his sexual fantasies and organismic feelings about other men and has begun to pretend he is sexually attracted to women. As he introjects society's values he tries to become who he is supposed to become rather than who he really is. When he realizes that stifling and pretending cannot make affection, emotions, and sexual feelings disappear, he begins to hate that part of himself that society rejects. The task of the therapist is to help the client learn to discriminate between the negative values he has introjected and his true organismic feelings and beliefs.

GAY MALE STEREOTYPES

The client who is coming out and developing a positive gay identity has most likely introjected many negative myths and stereotypes about gay men. Some of the stereotypes include: Gay men want to be women, Gay men hate women, All gay men are effeminate, All gay men are attracted to young boys, and Gay men work only in the arts, cosmetology, or design. Some gay men fit these stereotypes, but myths and stereotypes have been used primarily to keep people in the closet. Occupationally, gay men are physicians, lawyers, nurses, teachers, scientists, businessmen, counselors, welders, farmers, and bus drivers as well as designers, artists, and cosmetologists. Many gay professionals have formed their own organizations such as the Association of Gay Psychologists-For Women and Men, Gay Teachers of Los Angeles, and Southern California Physicians for Human Rights.

BEING GAY AND MALE

A third set of introjects the client needs to examine are values about masculinity. Most gay men have not escaped the narrow definition of masculinity in our culture (Kleinberg, 1978). Traditional values about being a man have required that he be aggressive, competitive, unemotional, violent, overly intellectual, and in control of himself and others. Men have been told that their importance is based not on who they are but on what they should do: work hard, make a lot of money, be a breadwinner, find an attractive woman to marry, and father children. Clients often report that they don't feel like "real men" because they haven't accomplished what their heterosexual counterparts have accomplished. The traditional rites of passage into adulthood (marriage and children) are not part of the gay man's experience.

SEXUAL VALUES

A fourth set of introjects that seriously affect gay men who are coming out are those revolving around sexual values and monogamy. The cultural values have been very specific: Sex should be in the context of love, preferably sanctioned by marriage, and monogamous. Reevaluating rigid ideas about sex, love, marriage, and monogamy is especially difficult but essential for gay men who have had a strict religious upbringing.

CONTACT

A second important aspect of gestalt therapy is *contact*, which pertains to the existential shared meeting between two people as described by Martin Buber (Friedman, 1976; Yontef, 1976). The qualities of this type of contact, which in its most evolved form is the "I-Thou" relationship, include the recognition and acceptance by both persons of their differences and simi-

larities, without needing the other person to be any different than he or she is. On the part of the therapist contact requires empathy and the ability to imagine oneself in the other person's experience while retaining one's own identity.

Contact with the therapist during the initial phase of therapy with the client who wants help in accepting his gayness is important. Contact is likely to occur when the therapist shares empathy, caring, and acceptance of the client's experience.

For example, Greg is a typical gay client seeking therapy because he wants help in accepting his gayness and coming out. He is in his mid-twenties, college educated and has worked for two years with the same marketing research firm. He tells me that the weight of the turmoil and confusion about his sexual orientation is becoming too much to handle alone. Through a female co-worker he received the phone number of the local gay and lesbian center, but being too afraid and ashamed to be seen going there, asked for a referral to a professional counselor. During the first session I hear pretty much what I always do as he nervously spills out his story.

He knew he was "different" as early as elementary school but didn't have any words for it. He identified somewhat with the word "sissy," but he liked some sports so it didn't seem to totally apply. In high school he dated because he felt the pressure to conform and thought the intense affection and sexual feelings he felt towards men would disappear. In college he spent most free time studying or being involved in campus politics. He dated some, and had one brief sexual affair with a male roommate, after which he felt very guilty. He realizes that he is gay and wants help in coming out.

During one of our early sessions Greg complained that he feels aloof, is disconnected from people, and has a difficult time communicating with others. In the session we discovered that as he talks he makes no eye contact with me, looks mostly at the floor, mumbles a great deal, and seems to be having a monologue with himself rather than a dialogue with me. I share nonjudgmentally that I am feeling cut off and disconnected from him.

Once he is aware of what he is doing moment by moment, I suggest he begin to experiment with making eye contact, speaking more clearly, and speaking to me as if he wants me to hear him. During the experiment he reports that he feels he is communicating more effectively with me.

As we continue to focus on Greg's loneliness we discover his pattern is to wait for friends or acquaintances to call him rather than his taking the initiative to call them. When they don't call he gets angry and feels sorry for himself. Greg is becoming aware of how he cuts himself off from others by waiting for them to call him.

But that new insight does not excite him as did the awareness of how he cuts himself off from me in the session. Further discussion reveals that Greg has a poor self-image and imagines that no one would want to spend time with him. He states that he feels like a failure because he isn't living up to everyone else's expectations of him, an example of how introjection can lead to guilt and shame.

REDISCOVERING ONE'S BODY AND EMOTIONS

While the focus of initial awareness work is to undo the introjected values from parents, church, school, and society, another phase of awareness work is that which aids the client in discovering and developing sensory awareness of his body and emotions. Gay people have often lost awareness of their own feelings and have learned not to trust those of which they are aware (Clark, 1977). It is not unusual for the client to be unaware totally of his present physical experience. He has given up the use of his senses and bodily feelings and trusts only his mind. The excitement, spontaneity, and creative physical expression seen in young children are simply absent in most adults. Ironically, bodily senses and excitement are

how one first comes to recognize his gayness. For many gay men the physical warmth, tingling, and excitement that accompany caring about and being physically attracted to another man have been removed from awareness by being numbed, ignored, or redirected. One can tell his body anything he wants, but in the end his body is the ultimate truth say.

For example, as Greg spoke about his brief gay relationship in college I noticed that his eyes welled up and that he cleared his throat repeatedly. He was obviously having an emotional reaction as he talked about someone he felt close to and related to sexually. I asked him to stop talking and to pay attention to his physical experience. He stated that his face felt very warm and he felt choked up. I asked him to continue to pay attention to his bodily sensations as he continued to talk. I asked him to imagine his college roommate was with us and to say whatever he would like to say to him. Greg barely got the words out before he began to sob. He discovered that he was very much in love with this man and still missed him. He was saddened by the fact that their relationship ended in an unfriendly way and that he had not seen him since graduation. Greg was very surprised that he still had such strong feelings for someone he had not seen in several years. He was even more surprised because he usually never allowed himself to cry.

This example clearly illustrates that when bodily sensations are discovered and reowned one is likely to rediscover a large portion of one's emotional experience.

SUPPORT

A third important concept in gestalt therapy is self-support or maturity. Support in gestalt terms is that which makes contact possible. It includes anything—food, air, ideas, values, experiences—that aids the person in self-knowledge, developing his potential as an individual, and becoming more himself. There are two kinds of support: self-support and environmental support. Self-support indicates that the person is either able to provide for her or himself that which facilitates growth or else direct the effort to find it in the environment and move towards it. People without self-support expect the environment to take care of their needs.

Greg recognized that he was not able to handle coming out as a gay person on his own. He was being self-supportive by finding a therapist who would help him in the process. If he were to sit at home expecting someone to come along to help him undo the homophobic and antigay attitudes he had introjected, he would be relying on environmental support.

Since the client has experienced no support from the environment for being homosexual, some environmental support during the initial phase of coming out is important. It is unrealistic to expect the client to move from a strongly negative gay identity to accepting his homosexuality without some intermediary support. The therapist can provide some of that initial support by providing the client with accurate information about the gay community and a perspective that includes both homophobic and progay value systems. The therapist can serve as an important resource person to the client at this time by directing him to positive readings or lectures about gay life so he can begin to read and hear about the positive aspects of the gay experience. Informing the client that our culture is indeed homophobic and antigay and that there has been a conspiracy of silence about homosexuality and a widespread effort to extinguish its existence helps the client feel he is not solely responsible for his situation. Hearing that he is not alone either in his homosexuality or his discomfort about it can be validating and supportive.

The self-supportive person in gestalt terms is one who is able to see and accept others and the world as they are without needing to change them to feel okay about him or herself. It

also means being able to recognize and accept that one is okay and loveable, even though different from others. For example, loving and respecting oneself as Black, female, or gay in a culture that is racist, sexist, and antigay requires a lot of self-support and maturity. On the other hand maturity does not require simply sitting back and allowing oneself to experience discrimination and prejudice. Self-support for a gay Black man may include moving from a small town that is racist and homophobic to a large city where he might experience less prejudice and discrimination and get support from other gays and Blacks.

COMING OUT FEARS

There are many fears associated with coming out as a gay man. Lesbians and gay men frequently lose their jobs, homes, friends, family, and worst of all their children because of homophobia and antigay prejudice. Antigay laws, attitudes, and mores are just beginning to change. Only a few cities and counties across the country have passed legislation protecting lesbians and gay men in areas such as housing and employment.

Since it will be many years before antigay discrimination lessens significantly, the client needs to learn how to develop support to function as a gay person in an antigay culture. Information and resources about the gay community are important tools to help develop that support and to decrease some of the fears of coming out. For example, many large cities have neighborhoods that are predominantly gay. A move from the suburbs or across town into such an area might decrease the fear of being verbally or physically assaulted. Gay men who work with children fear for their jobs. If the client is aware that there are many groups and organizations fighting antigay discrimination cases and winning, he may be less afraid to come out. These kinds of facts are important to the survival of someone who is wrestling with coming out.

The fear about losing family and friends, however, is often justified. Some gay people get support from their families and friends, but most do not. Helping a gay client go through the experience of being totally rejected by his family is not easy. Time often heals the pain of the loss. Hearing from one's parents such words as *filthy*, *disgusting*, and *scum* is something not easily forgotten. Being with other gay people as one begins to realize some of the harsh realities of being gay in a homophobic culture is essential. Sometimes therapists must encourage their clients to attend a gay rap group or gay therapy group because the client is still experiencing his own homophobia. After several meetings with other gay men, however, he often finds their support invaluable and begins to grasp some of the joys of being gay.

GAY CONTACT AND SUPPORT

Every gay person has learned to feel different and usually very negative about that difference (Clark, 1977). As the gay man learns to feel good about being gay, it is essential that he have contact with other gay men who have positive gay identities to counter or reverse the negative identification he has experienced (Jacobs & Tedford, 1980).

It has been my personal experience, and the experience of most gay men I know, that actually meeting and getting to know another gay man who felt good about his gayness was the most powerful factor in helping to accept one's gay sexual orientation and to develop a positive gay identity. The phenomenon of meeting another gay person for the first time is difficult to describe, but it comes close to resembling the difference between having someone tell you what you look like and being able to look at yourself in a mirror.

At every weekend group for gay men I have led, at least one person has commented on the positive and powerful support he experienced by just being with 12 other gay men for an entire weekend. Talking about coming out and developing a

positive gay identity are important, but being with and experiencing other gay men in a supportive environment is much more powerful. Gay support takes many forms. It is hearing ideas, values, and experiences of someone who has made the journey and transition from self-hate or confusion to self-love and affirmation as a gay man. It is sharing one's own struggle. It is being able to hug or touch another man or hold his hand as he experiences some of the remembered pain of his past.

Unfortunately, not every small town has a gay rap group or gay bar, so finding other gay people to identify with and relate to may mean frequent trips to the nearest big city. If the client wants more gay support than visits allow, suggest that he relocate to a larger city where he can begin to meet other gay men and make gay friends.

After the client has accepted his gay orientation, come out, and begun to feel good about being gay, there will be additional issues to work on. One such issue is social isolation (Babuscio, 1976). The guilt, shame, and other negative feelings the client has felt for years are not going to disappear in a few weeks or months. The vestiges of these negative feelings cause some gay men to isolate themselves socially. Again, gay groups can be particularly helpful: rap groups for some men and therapy groups for those who need the safety, support, and continuity of an ongoing group and therapist.

ONGOING SUPPORT

Gay people are a unique minority group. Rather than getting support from their biological families, as with most minority groups, gay people tend to get judgments, guilt-inducing interrogations, rejection, and sometimes hostility and physical assault. Another type of support that is essential after the client has come out is a gay family or gay support group capable of caring and helping, and providing ongoing support. Clark (1977) describes how to form such a group.

COUNSELORS FOR GAYS

Who is best suited to work with gay clients? I agree with Clark (1977) that in order to work with gay clients the therapist must not only accept but also value his or her own homosexual thoughts, feelings, fantasies, and behaviors. If the therapist has not come to appreciate his or her own homosexuality in whatever form it exists, some homophobia will eventually be communicated to the client. The therapist who wants to help the gay male adjust to his "problem" is certainly less homophobic than the therapist who is still offering cures, but the idea of "adjusting" to one's "problem" (homosexuality) indicates second class citizenship that is unacceptable.

The therapist who wants to work with gay clients needs to be aware of her or his prejudices and stereotypes. It is the therapist's responsibility to inform the highly homophobic client that the myths and stereotypes are not representative of most gay men. If the therapist is not gay or lesbian the client needs to know that the therapist has no negative judgments about homosexuality and can actually value the client's homosexual thoughts and feelings. The therapist also needs to have an open mind and broad range of what is healthy male behavior and what is healthy sexual behavior. Some gay men have developed their own sense of being a person that excludes much of the traditional male programming.

If counselors are going to be effective they must know about the gay male subculture, which is large, diverse, and more heterogeneous than one might expect. There are medical and sexual problems unique to gay men. There are spiritual practices and political issues unique to the gay male subculture that may play an important part in a gay man's life. Several books that describe some of the diversity of the gay subculture include *Lavender Culture* (Jay & Young, 1978b), *The Gay Liberation Book* (Richmond & Noguera, 1973), *Homosexualities* (Bell & Weinberg, 1978), and *The Gay Report* (Jay & Young, 1978a).

Since one of the most important aspects of developing a positive gay identity is being in contact with gay people who are already forming their positive gay identities, the therapist needs to be aware of where the gay client can find gay people who feel good about themselves. In large cities there are often special centers and programs for gay people with special needs, such as gay fathers, gay teenagers, gay alcoholics, or gay men who are heterosexually married. The therapist who wants to work with gay people needs to be aware of these resources.

People often ask if gay clients should be seen only by gay therapists. Generally, if a gay client or a client who is seeking help in coming out wants to work with a gay therapist that request should be respected. My experience is that most gay clients prefer working with gay therapists because either they have been treated by a nongay therapist who tried to cure them of their homosexuality, or because they simply feel more comfortable and trusting with a gay therapist. Obviously, there is not always a gay therapist available to work with every gay client. It is therefore important that nongay therapists learn about gay people and gay culture, and retrain themselves to work from a nonhomophobic point of view (Berger, 1977; Woodman & Lenna, 1980). Some nongay therapists have done their homework and are qualified to work with gay clients. Sometimes a nongay therapist is an asset, as in the case of the gay client whose homophobia is so great he does not want to see a gay therapist. In that situation it is critical that the nongay therapist be accepting, informed, and nonhomophobic.

CONCLUSION

When the homosexual male who is struggling to come out comes to therapy, he is making a significant statement. He is

acknowledging the possibility that he may be gay, often the most difficult step in coming out. The primary goal of working with the homosexual male, who wants help in coming out and in developing a positive gay identity, is to help him overcome his negative gay identity. From a gestalt perspective, focusing on awareness, contact, and support are essential concepts. Initial awareness work needs to focus on the negative societal values he has introjected regarding homosexuality, gay stereotypes, the male role, and sexual values. Later awareness work needs to focus on helping the client recontact the aliveness, excitement, and sexual feelings about other men that he has pushed out of awareness. As the homosexual male begins to come out and develop a positive gay identity, the most important support he needs is contact with other gay men who feel good about themselves. Every gay man needs a gay family or gay support group. The therapist who wants to work effectively with gay male clients must value her or his own homosexual feelings or be nonhomophobic. He or she must not be confined by traditional values about the male role and sexuality and must know how to help the client find the gay resources and gay support he will need.

"Coming out of the closet" is a positive acceptance of one's homosexual feelings and acting on them free of guilt and shame.

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I want to express my appreciation to Don Clark, Ph.D., and Gar Yontef, Ph.D., who have been powerful and positive influences in my development as a gay person and as a therapist.

In this century both the literature and social programs devoted to adolescent pregnancy have focused almost exclusively on the female. This article presents profile of teenage fathers by reviewing the scant literature that is available. The authors make specific recommendations for counselors on the basis of this review.

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homosexuality in humans (as in animals) might function in preserving the human species by natural selection. In any case, Dr. Socarides should not assume that all homosexuals are capable of being good parents. Lesbian mothers and gay fathers do exist. Dr. Socarides is entitled to his personal beliefs about the pathology of homosexuality—despite substantial scientific evidence supporting the effectiveness of therapy for homosexuals. The American Psychiatric Association's endorsement of therapy for homosexuals is a discreditable attempt to justify its position. It is irresponsible to advocate a treatment for homosexuality that has been shown to be ineffective.

Dr. Socarides points out that we are obligated, as health professionals, to provide up-to-date information about homosexuality to the general public. Dr. Socarides has provided no evidence that homosexuality is inherently pathological. In fact, he has shown just the opposite—that homosexuals are no more psychologically adjusted than heterosexual women in psychological adjustment. Psychiatrists should develop a new understanding of homosexuality and its alternate lifestyle.

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 Attachment and Autonomy in Lesbian Relationships.

Sexual Arouse Therapeutic Concern? *J. Homosex.* 2:235-

Bereavement Counseling for Gay Individuals*

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Complexities and complications which confront gay bereaved, e.g., lack of societal mechanisms, sanctions, and resources to aid in the bereavement process are identified and examined. Case material is used to document and delineate these and other special considerations. Therapeutic recommendations for working with bereaved gay patients are presented.

Mourning the loss of a loved one is a painful experience. It involves dealing with emotional, physical, and spiritual experiences which may lead the individual to feel disoriented, depressed, immobile, and suicidal. For the gay bereaved there are additional problems which complicate the grieving process. The purpose of this article is (1) to demonstrate that grief counseling is needed by gay persons who are lovers, "spouses," friends, and partners of the deceased; and (2) to present case material of bereaved gay individuals to supplement the clinician's knowledge of the dynamics of grief counseling.

Jackson describes grief as follows: "Grief is the intense emotion that floods life when a person's inner security system is shattered by an acute loss, usually the death of someone important in his or her life."¹ The pain at the loss of a significant other may be intensified by acute reactions such as headaches, insomnia, loss of appetite, and a sense of panic. Furthermore, as Jackson continues, "Grief is the silent, knifelike terror and sadness that comes a hundred times a day, when you start to speak to someone who is no longer there."¹

The bereavement process is not linear. According to Parkes the following stages of grief may recur: alarm, searching, mitigation, guilt, anger, and gaining a new identity.² The process of mourning is layered. When the layers come off, previously discarded layers may be "worn" again. For

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example, a person who felt numb during the first few days of mourning may re-experience that feeling on anniversaries of the death.

Mental health professionals and health care providers in the last decade have witnessed a surge of literature outlining the need for grief counseling, diagnostic considerations, treatment plans, and supporting case histories. The majority of the literature currently addresses the loss of a relative, e.g., a parent, spouse, sibling or child. Clinicians have previously been provided with guidelines to help clients through the grieving process when the deceased and the survivors are heterosexual.

There is a paucity of literature dealing with the grieving process of gay persons who encounter the cruelty of society's antihomosexual stigma while simultaneously mourning the loss of a lover or "spouse." This article will outline a few major considerations that face the gay bereaved.

A stigma is often attached to any survivor who has lost a significant other. Parkes characterized this stigma as: "a change in attitude that takes place in society when a person dies. Every widow discovers that people who were previously friendly and approachable become embarrassed and strained in her presence."² Goffman defines stigma as "the situation of the individual who is disqualified from full social acceptance."³ Furthermore, he outlined three categories of stigma including homosexuality under "blemishes of individual characteristics."³ Because society conditions its members to feel apprehensive toward those who lead alternative lifestyles, it is more difficult for gay men and women to receive support while they mourn their loss. Society does not sanction intimate, same-sex relationships; yet it is the lack of sanction for this type of relationship that prolongs the grieving process. Hence the gay bereaved experience a double stigma, and reactions to these added stresses vary widely.

The following are cases which illuminate the particular concerns and unique situations that the bereaved gay experience.

Case 1

A., a man in his late twenties, began therapy after a recent move to San Francisco from a northern town. He found work, but accepted a lower pay scale than he had been earning as an insurance broker in the rural town. His lover had committed suicide three months previous to his move, just prior to Christmas. His lover had been under investigation by the school district, not due to sexual activity, but in regard to comments he reportedly made to staff and students and had been fired from his job as a teacher in a junior high school.

A.'s lover committed suicide while visiting his parents on the east coast. A. stayed in California for the holidays. His reaction to the suicide was shock and withdrawal. He went to his lover's funeral, but was unable to engage his lover's family in a level of communication in which he could safely express his grief. He quit his job upon his return from the funeral. Additionally, he stopped attending the gay people's group

in which he and his lover had previously participated. Because seeing the members of this group and hearing their concerns generated by the firing of his former lover re-stimulated memories of his lover and intensified his suffering, he withdrew from the group.

His unexpressed grief made him too vulnerable in the group setting. He had not been aware of the stigma attached to him because he was mourning someone. His awareness of the "mourner's stigma" from other gay persons did not occur to him until he entered therapy four months later.

There are several considerations which need illumination from this case. One issue is concerned with self-disclosure. Once one's mate is dead, the gay survivor like any other bereaved person may be subject to investigation by doctors, the police, and the coroner, and thus running the risk of being exposed suddenly or unexpectedly to potential antigay stigma. The deceased's relatives, especially those who were not aware of the deceased's lifestyle, may desire further questioning. This infringes upon the survivor's privacy, creating an emotional conflict regarding self-disclosure and adds stress to the bereaved's situation. If there is not even a minimal social support network, the survivor is more likely to move, escape or embark upon a major life change rather than cope with the added stresses.

Additionally, emotional problems associated with concealment of a social stigma may be heightened during the mourning process. Men in particular have had to suppress their urge to cry at a lover's funeral. Thus, a typical conflict to anticipate would be whether or not to appear in public at this time. Moreover, by withholding emotions, the survivor may say he or she is "just a friend of the deceased." When concealing the truth about their sexuality, many gay people attempt to pass off their intimate relationships as roommates or friends. Hence, the depth of emotional pain during the grieving process may be intensified, self-esteem further damaged, and grief feelings channeled into self-destructive behavior.

Case 2

B., a 60-year-old man, did not experience the full weight of social stigma until his lover died. As a couple, they experienced a comfortable, social acceptance for years among their heterosexual friends and neighbors in an upper-income suburb, as well as their business-executive and gay friends. The deceased had been wealthy and socially prominent. Over the years they had become recognized and accepted as a couple. After the funeral, the friends the survivor thought were his began to ignore him. Similar to a widow, he was ostracized from his social network; not invited to dinners as he had been before his "spouse's" death. His phone calls were not returned, he felt acutely despondent, "gave up" and withdrew from most of his friends. His only contact was the minimal amount he needed to maintain his part-time store business. For over a year he was in a state of chronic depression. No longer a partner in a couple, his presence, like that of a widow, created awkwardness and

his previous social friends and acquaintances. B. was avoided not simply for being gay, but also because he reminded others of the impermanence of life. Feeling the onus attached to his gayness and resenting rejection, his grief and difficulties in instigating new social contacts that would validate his positive gay identity caused him to become depressed.

B.'s mate had died shortly before a cruise they had planned to take together. In an attempt to console himself, B. went on the trip with a new acquaintance, a man thirty-five years younger, who was an alcoholic. His expectations of the young man's affection and caring were never realized, and he soon discovered that the young man could not fulfill his longing to be loved again. Such attempts to duplicate the lost relationship by the survivor is self-destructive, a sabotage to prevent the unloading of deep feelings of loss and resolution of grief. B. did not enter therapy until he re-experienced the shock on the anniversary of his lover's death one year later and again encountered the deep depression, insomnia, and physical weakness he first experienced at the time of his lover's death.

Guilt is one of the anticipated reactions the bereaved experience after the death of a loved one. For gay people, the "If only I had done . . ." type of guilt may be exacerbated by the guilt about their sexual preferences. Guilt may take on many forms following a lover's death, conflicts regarding one's sexuality may resurface. A lover's death, particularly if it was a suicide, may restimulate old self-doubts, feelings, and insecurities about being gay.

Case 3

C., a young college student who had recently "come out," was in couple therapy with his lover to work through issues of monogamy and trust. Upon finding out that he was seriously ill, C.'s lover committed suicide while C. was visiting a mutual friend for the weekend. C. felt totally responsible for the death of his lover. He attended the funeral service and fortunately found the deceased's parents compassionate and sensitive to his needs. He was able to resolve some of his remorse. However, guilt feelings about being gay returned, interfered with his ability to study and complicated the progressive movement through his grief process. He felt unable to express the helplessness and anger he felt after his mate's suicide. He continued in individual therapy for one year exploring his feelings and eventually was able to renew his positive social identity and return to college.

Another pertinent consideration in grief counseling with gays is the survivor's social network. The more dependent the survivor has been in the relationship, the more likely it is that the after-effects of the shock and/or searching episodes will be acute and longer lasting. If a person can reach out to other gay persons and transform feelings of loss, anger, guilt, and loneliness into feelings of self-regard and self-interest, it will be easier for that person to be validated in his or her social identity. Particularly for gay persons, the social network functions as the mainstay of support and self-expression during times of identity reformation, and provides resources

during a personal loss. Without churches, families or a work environment where deep feelings can be expressed safely, the social network is the clinician's focus for intervention and ego development.

The following case illustrates some of the dynamics of social networks:

Case 4

D. is a 55-year-old man whose co-workers accepted his social identity without stigmatizing him. They were supportive of him following the death of his lover, who had died from a heart attack. Some of his fellow workers were part of his personal social network; however, they were 15 to 30 years younger than he was. His appearance and hobbies became that of a young man: Adidas, jeans, knit shirts and disco dancing. He centered his social network around men at work and nearby apartments, who were also many years younger, approximately the same age he and his lover were when they first met. When he began therapy, he complained that although he could find as many lovers as he liked, he did not enjoy his passing relationships with young men. He did not increase his social network to include men his own age and maturing lifestyle. He was searching for the imitation of his dead partner. As a result of therapy, his social network was enlarged and he learned he did not need to be "young again" in order to gain intimacy.

Another area of conflict to anticipate is that there are common rituals in American society for the dead and dying which may not be available to gay survivors, and may even communicate disrespect to them. For example, in a hospital setting, especially in an ICU situation, the gay partner is rarely afforded the same courtesies as blood relatives. If the gay partner and the patient's blood relatives are both present there may be increased tension between them. Usually, the gay partner leaves, frightened and angry without venting painful feelings. Also, when death of a partner occurs, a gay person may feel like a "non-person" since newspapers do not acknowledge gay survivors in the obituaries. Society does not allow for a normal expression of grief or paying of respect to the gay bereaved.

Case 5

E., a lesbian, recounted an example of G., a friend of hers who earlier in her life was married, got divorced, and later expressed herself as a lesbian. G. was only eulogized at her funeral for her virtues as a wife and mother without any mention of either her life as a lesbian or her work for the advancement of lesbians. E. found it very painful that G. had been buried "straight," without recognition of G.'s happiness with her lover.

This article does not contain as many lesbian cases as gay male cases due to the fact that at the time of this writing, the authors did not have many lesbian clients who were bereaved. The authors attempted to be sensitive to the issues that face all bereaved gay individuals.

Usually friends of someone who dies are only excused from work to attend funeral services, while persons related by marriage are often granted an extended leave of absence if requested. In the case where sexual identity is concealed, a request for an extended period of time off may raise suspicions or simply be denied to "a friend" of the deceased. Also, when the deceased is a same-sex friend, the gay survivor's fluctuations in mood and other grief reactions can irritate co-workers who do not empathize with the depth of feeling which the survivor needs to express. When counseling the gay bereaved, ways to allow the opportunity for the expression of grief should be encouraged, such as taking a vacation earlier rather than taking time off without pay or leaving the job.

The lack of resources designed for gay people creates an even more difficult situation. When one is gay and lives in a community where homosexuality is not considered a human right, where does one seek solace? She or he cannot go to a priest because gays are considered sinners. Gays may not be able to go to a doctor, lawyer or work supervisor for fear of exposure, a potential jail sentence, loss of a job or status in the community. Nor can they expect to get support from their families for fear of rejection. The likelihood of going to one's family is very rare.

Support Agency

Often gay survivors are so deeply depressed by the time they seek professional help that they have already become self-destructive, as in Case 1 where the survivor quit his job and moved to a city where he received a lower salary; and in Case 4 in which the gay man behaved inappropriately for his age, trying to become a young man again. Self-destructive behavior (which often includes increased drug and alcohol use), masochistic behavior, obsessive interludes during work, taking a new lover quickly after the death of another (regardless of differences in age and temperament), and giving in to general aimlessness are common, destructive patterns in the process of grieving which need direct preventive intervention.

If the bereaved shows evidence of having an impulsive or cyclothymic personality, he or she is more likely to become violent or suicidal. Careful assessment of risk or sudden change of mood should be noted in these cases. For instance, an early sign of self-destructive behavior in the case of Mr. D. was the way in which he quickly formed surface relationships with dependent, younger men, and then resented their flippancy and lack of commitment. His caretaking relationships with younger men were self-destructive in that they were motivated by his searching for his dead mate. He was unaware of his own desire to be taken care of by his deceased partner.

Self-destructive behaviors are also likely to emerge following a visit by the patient to his or her own family. Often with one's own family, the

lesbian or gay male experiences additional discomfort, guilt, anger or boredom. The need to ventilate increases after such a visit.

Agency Structure

Two last issues require discussion. The structure of a social service agency is very important. Eligibility regulations may preclude gays from seeking help. For example, the very term "Family Service Agency" implies service for the traditional family unit. This is recognized by gay people to exclude them and consider them unfit for treatment except to "change" their sexual preferences. Utilization of a community service may be frustrated by catchment area requirements and regulations governed by location of residence. All district health centers in the same county may not offer similar services, only one center may offer special services for gay clients. Furthermore, there may be a low awareness among gays of mental health services that are available and respectful to lesbians and gay men. Even in a city like San Francisco, where there are several gay mental health service agencies, many gays remain unaware of available resources in their community.

Finally, a discussion of mental health resources for a lesbian or gay man in mourning is not complete without raising the issue of the quality of therapeutic rapport. The gay client's only resource of a supportive relationship may be a mental health professional. How the therapist chooses to receive a gay client will determine the effectiveness of the ensuing therapeutic relationship. As Clark asserts "Mystery and misinformation about the unknown breed fear. Fear feeds prejudice and cruelty."⁴ A grief counselor should be aware of his or her conscious or unconscious thoughts, attitudes, and responses to gay lifestyles. The therapist unfamiliar with gay counseling would benefit by reading literature regarding the history of the gay and feminist movements. Hopefully, also, the hospice movement will begin to respond to the needs of dying gays, intimates, relatives, and friends. *The general focus of grief counseling is to support the survivor through their process of mourning rather than attempt to change their sexual orientation.*

The clinician can help lesbians and gay men in grief counseling throughout the process of grieving by helping them let go of an intimate, significant other and develop positive, specific changes in their personal growth and social interactions. The therapist may feel like he or she is the sole means of support since the social environment may not be supportive of persons engaging in same-sex relationships and ignores gay people when a death occurs.

The therapist must be able to realistically assess the possible alternatives for lesbians or gay men in their own social environments. If the therapist's awareness and information about these communities and lifestyles are

limited, the client should be referred to a practitioner knowledgeable of the client's community patterns. A bereaved gay is in need of social resources in his or her own community lifestyle; hopefully, the number of therapists within the gay male and lesbian communities, and smaller social networks will increase and organize needed social resources for the gay widow, widower, and intimate friend or relative.

The therapist should be aware of the patient's reactions to the stigma of being gay, as well as to the stigma of being a mourner, and help the patient distinguish these feelings. Moreover, as previously mentioned, delayed grief reactions on anniversaries or some other special date in the former relationship are not uncommon. Hence, the therapist and patient as a team might explore specific individualized strategies or rituals to acknowledge these events and thereby enhance the mourning process. For example, one of the authors has in her work with heterosexual and homosexual and lesbian patients, helped them identify and establish their own personal strategies which symbolized commemoration and "letting go." Examples of patients strategies include completion of a photo album; creation of a poem, dance, painting; the establishment of a specific time for a private conversation with the deceased, or the lighting of a candle. Such strategies are not unusual if one considers religious rituals for the acknowledgement of the deceased, (e.g., in the Jewish religion, a special candle is lit on the anniversary date of a death of a family member.)

A nurturing therapeutic relationship will often lead to great rewards for therapist and patient. Both will observe the patient's progress from a stage of intense pining and pain to a renewed awareness of strengths, growing sense of identity, and deeper engagement in a social network of friends and intimates. Finally, resolution of mourning may be accompanied by less guilt, greater self-esteem, and stronger coping mechanisms to meet life challenges.

SUMMARY

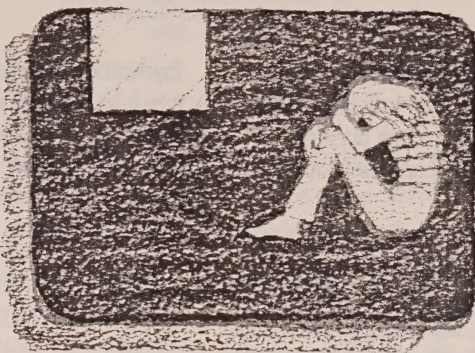
This article is intended to sensitize therapists to the particular concerns of the gay bereaved. Clinicians need to be aware of and accept homosexual and lesbian lifestyles as well as knowledgeable about grieving procedures before engaging in a therapeutic relationship with gay bereaved individuals. If the therapist has minimal information about either of these areas, the patient should be referred to another clinician who is more informed. The therapist and patient together should explore the possible mechanisms for a bereaved lesbian or gay man to cope with within his or her social environment. While it is now less of a problem than in the recent past, there is still little awareness of the specific problems homosexuals encounter and society has few structures to deal with them. Homosexual and lesbian couples who mourn their mates need to be seen and see themselves as worthy of support.

Acknowledgement: The authors wish to thank all the lesbian, gay male, and heterosexual therapists and clients who assisted in the preparation of this manuscript.

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DEPRESSION—A GENERAL SURVEY



The major symptom of depression is a fairly prominent and persistent loss of pleasure and interest in former activities and pursuits.

WHAT IS DEPRESSION?

The major symptom of depression according to the American Psychiatric Association¹ is a fairly prominent and persistent loss of pleasure and interest in usual activities and pursuits. Feelings of sadness, hopelessness, and discouragement pervade the depressed individual. Symptoms usually accompanying the major symptom are:

- Decreased or increased appetite with significant weight change.
- Chronic insomnia or excessive sleepiness.
- Inability to sit still; pacing; hand

wringing; pulling or rubbing the hair, skin, clothing or other objects; and outbursts of complaining or shouting. The reverse of this may occur in the form of slow body movements; low, slow, or monotonous speech; and poverty of speech or muteness.

- Decreased sex drive.
- Fatigue.
- Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt.
- Inability to think or concentrate.
- Preoccupation with death or suicide.

(over)

Other reactions to depression may be that of crying, feelings of anxiety, irritability, fear, brooding, excessive concern with physical health, panic attacks, phobias, hallucinations, and delusions.

The causes of depression are not completely understood.² The current view is that depression has multiple causes that may differ for individuals or groups, depending on life history, psychological makeup, inheritance factors, and biological vulnerability.

SEX DIFFERENCES

More than twice as many women as men experience depression. Approximately 18 to 23 percent of adult females and 8 to 11 percent of adult males have had a major depressive episode.¹ The typical depressed female is aged 25-40, married, and raising children.^{3, 4}

AGE DIFFERENCES

Reactions to depression may differ within age groups.¹ Children may become anxious or clinging and refuse to go to school. Adolescent boys may become negative, antisocial, restless, grouchy, aggressive, or uncooperative. They may want to leave home, have school difficulties, dress carelessly, become emotional, be sensitive to rejection, or begin to use alcohol and drugs. (Symptoms of depression specific to adolescent girls are not given in the American

Psychiatric Association manual.) Elderly people may have difficulty in concentrating, be easily distracted, have memory loss, be indifferent, or become disoriented. Careful examination will reveal the core symptoms of depression in these specific age groups.

WHAT'S THE DIFFERENCE BETWEEN CLINICAL DEPRESSION AND FEELING "BLUE" OR "DOWN?"

The term depression can be used to refer to several related, but distinct conditions.^{3, 5}

Depression can refer to a mood that all of us experience at one time or another in response to disappointments, frustrations, etc. It is part of the ups and downs of normal life.

Depression can also refer to symptoms of sadness, loss of energy, inability to experience pleasure, feelings of helplessness, and bodily complaints that may be short-lived but that are outside the range of normal. Depression can also refer to a clinical syndrome which is characterized by depressed mood with associated features, persistence over time, and some impairment of functioning. Associated features may include appetite and sleep disturbances, loss of energy, feelings of pessimism, hopelessness, inability to experience pleasure, and thoughts of death and suicide. The depressive syndrome lasts at least several weeks and may last years.

HELP FOR REDUCING HOSTILITY

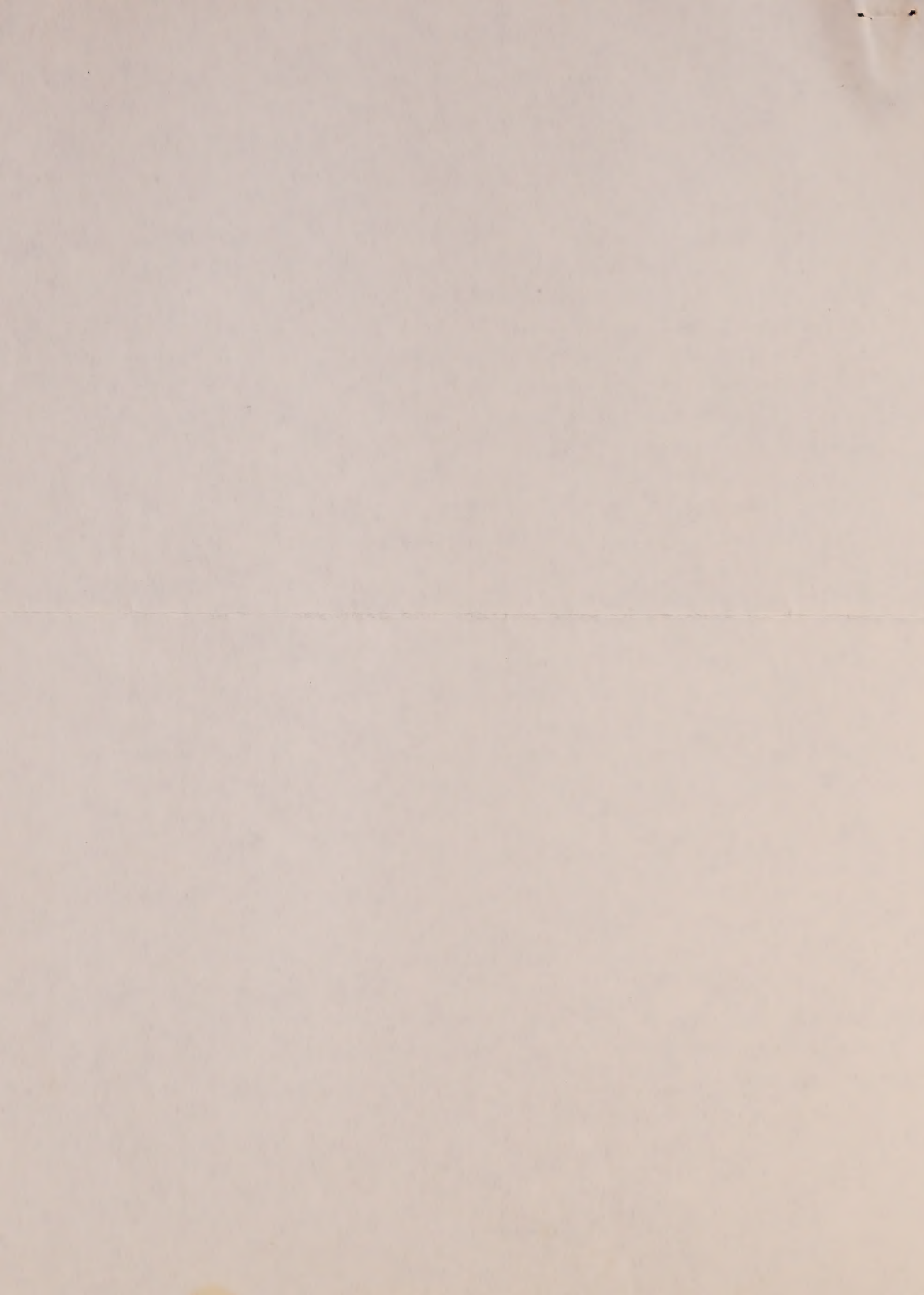
A nagging, critical, hostile disposition is a serious hindrance to everyone. It can prevent you from attracting a desirable mate, and it is often the cause of marital discord.

It is true that being critical.....meaning carefully selective----- can help you sometimes, as when you are making an important choice. But real hostility as we mean it here, refers to the personality trait of being fault-finding or exaggerating the shortcomings of another person, often in a somewhat vicious way.

You are hostile whenever you look at another person and dislike what you see. You can see the faults in a person or in his or her actions. In your own mind, the person or the action is judged and rejected. Herein lies the damage that hostility does in human relations. It makes people feel rejected, unworthy, second-best. A trait opposite hostility is called TOLERANT. Everyone wants to feel appreciated for what he or she is, wants to have his or her faults accepted with kindness by other people. A person who is overly hostile wants other people to change so that they can be valued more highly according to the hostile person's standards.

HOW CAN HOSTILITY BE RECOGNIZED

1. Do people frequently do things that annoy you so much that you feel you must tell them so.
2. Do you observe people carefully when you meet them and make comments to your family and friends afterwards about their behavior and dress?
3. Do you consider yourself unusually objective, with high standards? Is it important to you to try to make other people meet your standards?



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Think about your wife or husband, your children, your neighbors and friends. Do you put pressure on them to be different so that you can accept them more easily? Do you talk, either directly or behind their backs, about the changes you'd like to see them make?

4. How do you feel when you are criticized or attacked verbally? Can you remember how a wall of protection was built up to cover the hurt of words or attitudes which you consider unfair? If you have developed the habit of being critical, can you see how you produce feelings of dislike for yourself in the people who hear you criticize others?

5. Do you criticize without using critical words? Remember, the people nearest you, your family, close friends, and business associates, are sensitive to your attitudes, and can feel hostility when it is implied by your actions and gestures, as well as by your tone of voice, even though the actual words you speak are not violent.

WHEN IS HOSTILITY UNJUSTIFIED?

1. When it defeats your own purpose, in the same way that an over-hard scolding does, by building up a protective resentment in the other person.

2. When it is just wasting time because you are merely expressing grievances. Admit to yourself that your opinion is not always vitally important.

3. When you are inflating your ego by looking down on the person you are attacking.

4. When you are interfering in something that would be better left to some closer relative, to a physician, or to someone else who can provide professional help.

5. When it is a matter of taste or opinion---eliminate such criticisms.

6. When it is strictly none of your business.

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WHAT CAN BE DONE ABOUT HOSTILITY?

1. Recognize the feelings you have as they arise. Accept the fact that you have these feelings. Learn not to yield to the temptation of putting your unfriendly or offensive thoughts into words. If you are in a group where criticism is an "indoor sport" refrain from participating in it yourself. Just listen(or get up and leave.)
2. Realize that your criticism of others often stems from a desire to make yourself feel better. If others faults are apparent, one's own don't seem so large. When you can find another person to agree with you about some one's faults, it is even more reassuring to you.
3. Realize how criticalness can "snowball." Seeing others' faults makes you feel better; but disliking other people makes you dislike yourself and feel disliked by others. This becomes a vicious circle.
4. Be eager to express appreciation and praise whenever you reasonably can. This does not require flattery; appreciation may be given on the basis of what is good in the circumstances, rather than what is absolutely superior. For example, you can say something gratifying even about an amateur performer in high school dramatics.
5. Learn to evaluate, rather than to condemn. To criticize is to take a negative approach, and it places you in the offensive position of seeming superior, while the person you condemn is put in the position of seeming inferior. When you evaluate rather than criticize, you have an opportunity for mutual exploration and growth.

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6. Find a substitute for direct attack, such as reading together, searching jointly for facts, or examining the behavior of a third person as an example to the individual you are dealing with.
7. Recognize the fact that there are times when you have legitimate critical thoughts about others which must be put into words. Truth and tact can go hand in hand under such circumstances. Think what you want to say before you express the criticism. Carefully select the time and place; be sure that the criticism is made in private. It is a good rule to praise in public and criticize in private. Pick the time when the person you want to criticize is likely to be most receptive. Prepare him or her to receive it, if you can, by an introductory remark such as, "I'd like to clear up something, have you a minute? Be sure that friendly communication is established before you proceed. Then put your criticism as clearly and as concisely as you can. Sandwich the criticism between two compliments. Evaluate the results, not by whether you were right in the position you took, but by how effectively you were able to express your feelings, and whether or not your received a response of cooperation.
8. If you can, have someone close to you, with whom you can communicate freely, help you with your hostile feelings. Admit the fault that you see in yourself, and request your friend to point out to you where you are unnecessarily critical. To the extent that you can consciously do so, learn to overlook the faults in other people by thinking about and expressing appreciation for their better qualities. As you see improvement in yourself, you'll have good feelings about yourself which will make it easier for you to like other people, too.
9. How much do you drive others as well as yourself? If this is a problem, try one day of complete passivity. See how your world revolves without your immediate direction. Try not to attract attention to yourself for the day.
10. Be less suspicious. People are less concerned with you than you think. Each individual lives in his own orbit. Accept others' opinions and integrity. They may have the same ideas and wishes that you have, but express them differently.

APPENDIX C

Form for Psycho-Social Diagnosis

This is a suggested form for 1st year students to consider.

(Your agency may have their own forms for summaries or psycho-socials).

1. Study and Evaluation

- a) Identifying information about client and agency
- b) How does the person get to the agency
- c) Presenting problem(s) --
as client sees it or as seen by referral source
how and when did it develop
- d) What do we know about the current situation of the individual
that is pertinent to the problem - his behavior, his environment,
his strengths, his limitations
- e) What do we know about client's previous experiences and his
relationships with significant persons that might be pertinent
to the problem
- f) What additional study facts do we need to understand the client
and his problem

2. Treatment Plan

- a) What has client tried to do about problem
- b) What does he want to do about it (motivation)
- c) What do we think he can do about it (capacity)
- d) What does he want the agency to do
- e) What can be done in relation to agency setting and function

3. Treatment Objectives

- a) What are immediate goals as seen by client and caseworker
(therapeutic contacts)
- b) What are long term goals as seen by client and caseworker

4. Treatment Methods

- a) What specific methods and techniques (relate this to diagnosis)
do you plan to use

5. Concise Statement of Psycho-Social Diagnosis and Related Treatment Goals

Differential expectation for this according to level of student development. In second year of training, more is expected in terms of integration of ego functioning of client (seen from his viewpoint and the framework of his social environment).

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APPENDIX D

GUIDE FOR PSYCHOSOCIAL DIAGNOSTIC EVALUATION AND TREATMENT PLAN

(Your agency may have their own forms for summaries of psycho-socials)
This is a suggested form for 2nd year students to consider.

I. Study Phase:

Under the following headings select the most significant data which have been obtained in order to arrive at the psychosocial diagnostic evaluation. Do not include evaluative statements in Section I. These are to be included in Section II only.

A. Identifying Information to date

1. Family composition, marital status, date of marriage, birthplaces, birthdates, race, religion, occupation, income, military status; others in household.

B. Presenting Request

1. Who applied, when?
2. How did client know of agency?
If the case has been referred, state source, reason for referral as seen by referring person, client's preparation and response to it.
3. Request as presented by client.
4. Circumstances precipitating application.
5. Previous attempts at coping with problems either independently or with outside help. Specify previous contacts with agencies.

C. Description of Client(s) (As observed by the caseworker)

Appearance, dress, manner of speech, vocabulary, apparent intelligence, mannerisms, affect, etc.

D. Current Reality Situation

Indicating sources of information state facts and describe the behavior of family unit and of individual family members in relation to the areas listed below. Emphasize areas of achievement and impairment in social functioning.

1. Cultural and religious status
2. Occupational, school, and home responsibilities
3. Economic status
4. Environmental conditions (e.g., housing, neighborhood, etc.) etc.)
5. Health (physical, emotional, and mental)
Describe present symptoms, give confirmed medical and psychological diagnoses if available.
6. Social activities (friends, participation in organizations, hobbies, recreation, etc.)
7. Family relationships

E. Family Backgrounds

Give significant family and individual history covering areas listed under D, as appropriate. Indicate sources of information.

F. Casework Contact

Length and frequency of contact with family members; number of interviews; delays in contact, broken appointments; fee status; techniques used and client's response to them; facts about services offered, their sources, whether or not the services were used by client(s).

II. The Psychosocial Diagnostic Evaluation

The evaluative statement is formulated from the foregoing selected significant data. It points up primarily the strengths and impairments in social functioning in the family unit and each family member. The causal factors in the impaired areas are identified and the significant relations among them are indicated. Emphasis should be placed on how the family unit affects and is affected by individual members as this interaction is reflected in social functioning. Use A, B, C as guides

A. Evaluation of social functioning of the family unit and its members

1. Identify and appraise the strengths and problems in the social functioning of the family as a unit and of its members. Indicate the connections which exist between one area of impaired social functioning and another.

Appraise the adequacies and impairments in ego functioning of each family member. Relate this appraisal to the appraisal of social functioning.

State the internal and external dynamic and causal factors of the problem areas in social functioning in the family unit and its members.

2. Specify social, psychological and somatic classifications. (Indicate when confirmed by another discipline.)

B. Evaluation of caseworker's activity

1. Appraisal of the effectiveness of the techniques and services used in the study phase.

C. Areas for further exploration

1. Specify areas needing further exploration, and the reasons for this.

Indicate if consultation with members of other disciplines is planned.

Estimate the amount of time needed for further exploration.

III. Plan of treatment

- A. State mutually agreed upon family and individual problem(s) in social functioning currently selected for improvement; problem(s) which the caseworker sees as eventually needing attention in order to achieve improvement; and problems which, by plan, caseworker will not attempt to treat, or will treat only indirectly.
- B. Specify the immediate and long term treatment goals for the family and its individual members; indicate and explain the selection of clients and its expected effect on the individual(s) and on the family unit; indicate treatment methods and techniques to be used for each individual; identify the personal strengths and resources of the family and its members which are to be used, and the resources of the community and agency which will be made available.
- C. Appraisal of factors in selection of caseworkers, if pertinent.

IV. Prognostic Statement

- A. Anticipated outcome of casework treatment and its probable effect on the family unit and its members; estimated length of time casework treatment will be needed.

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THE WRETCHED OF THE EARTH BY FRANTZ FANON

A Book Review

Marge Ragona

I had read The Wretched of the Earth in a totally different context while I was teaching school in New Orleans, reading then for the political content. This time I reread it for its psychological content, and was amazed at what I found happening.

In a section entitled, "Colonial Wars and Mental Disorders," I found myself translating Fanon's terms of the Algerian war into terms of the inner city and Black ghetto. The Algerian man who found himself impotent following his wife's rape must be legion in the ghetto; the rage, the thought that his wife had been punished for his existence, the question of whether to have sex with her or not all must enter into the husband's thoughts. Rape is a condition of the ghetto.

Again, the question of rage and homicidal impulses. In the ghetto, one stands by and watches friends humiliated, beaten, even tortured by white landlords, the police, white gangs of teenagers. One is entitled to a sense of rage. One may feel like murdering those -- all whites -- responsible. Or one can begin to feel that all people, including one's own, are in the control of the enemy and begin to hate and distrust even one's own kind. The anger then becomes an acting out against all people. I was particularly struck by the policeman, French, who came home and hit his wife and children, because he spent all day beating people. I wonder if the ghetto cop doesn't react in somewhat the same way, and if his battered wife and children aren't victims of his senseless attempt to create order in a world of chaos. Even children are not untouched. Fanon describes two adolescents who kill a white playmate, because they saw themselves as part of a war between ^{Algerian} ~~black~~ and ^{European} ~~white~~. I heard in my head the chant I had heard so often on the playground -- usually by black children -- "A fight, a fight, between a Nigger and a white," as they stood around in a circle, hand-clapping, beating a tempo, encouraging their brother to fight harder. Did they, too, see themselves as engaged in a war and this one of the skirmishes?

Fanon described a young Algerian, an ex-Moslem Boy Scout, westernized and with a technical trade, who wanted no part in the war. He had his professional goals and was not interested in the national struggle. Suddenly, he was obsessed with the idea of his parents' considering him a traitor, and he began to starve himself, began to hear voices calling him a coward, and finally went out into the European quarter (where, incidentally, he could pass) and finally tried to take a machine gun away from a French soldier and was captured and later tortured. He needed to prove he was not a coward and a traitor. Yet, we in the past have praised the young and old "uncle Tom's" who accept our values, work toward our goals, and find themselves in the possible situation of being hated by their own people, distrusted and treated with disgust by their racial brothers and sisters, and wonder why they are neurotic or psychotic, and why they wind up in mental hospitals when for a while they had had it so good.

We also wonder at young white women who react with neurotic attitudes toward all black men, if they have once been raped -- but Fanon describes a young French woman who reacted to her father's death with a paradoxical reaction. Instead of being sorry and mourning him, she was glad he was dead because he had been one of the torturers of the Algerians and refused to accept his death benefits because she felt they were "blood money." I suddenly wondered if the young white women do not feel that they deserve the rape and fear more rape, but unconsciously present themselves in situations where it will happen because they feel a sense of guilt and involvement in the causation of the rage which produced the rape, and fear not only the rapist but their own feelings of having earned the rape by their being white. This thought is engendered particularly by the knowledge of sensitive, politically aware, young white women who have been raped and who are very upset years later and very much aware that their rapists were young black men.

Fanon's book helped me to make some connections between violent behavior and the political thought processes behind it, and I think it helped me to envision a way of being a counselor to a ~~an~~ angry Black person or ~~one~~ apathetic, depressed (and repressing violent thoughts by repressing all feeling). It was a helpful book.

a helpful book
of reading it in a different context is useful.

Careful - a generalization like this is dangerous & blaming the victims. Both parties (black & white) to rape may be victims in different reasons.

Good - so maybe he helped for you to state how.

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